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HEALTH SECURITY ACT—ANTITRUST PROVISIONS

HEARING
BEFORE THE
SUBCOMMITTEE ON
ECONOMIC AND COMMERCIAL LAW
OF THE
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
SECOND SESSION
ON
H.R. 3600

TO ENSURE INDIVIDUAL AND FAMILY SECURITY THROUGH
HEALTH CARE COVERAGE FOR ALL AMERICANS IN A MANNER
THAT CONTAINS THE RATE OF GROWTH IN HEALTH CARE COSTS
AND PROMOTES RESPONSIBLE HEALTH INSURANCE PRACTICES,
TO PROMOTE CHOICE IN HEALTH CARE, AND TO ENSURE AND
PROTECT THE HEALTH CARE OF ALL AMERICANS

JUNE 15, 1994

Serial No. 58



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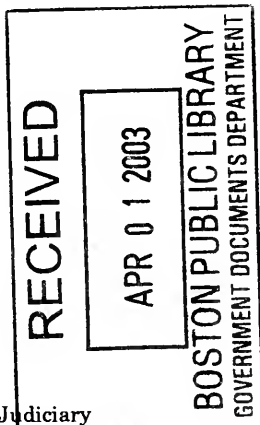
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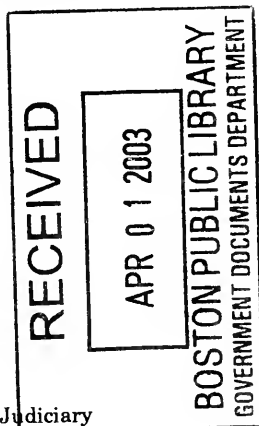


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CONTENTS

HEARING DATE

June 15, 1994	Page 1
---------------------	-----------

SELECTED TEXT OF BILL

H.R. 3600: Title I, Subtitle D, Part 2—General Responsibilities and Authorities of Regional Alliances, sections 1321 and 1322	3
---	---

OPENING STATEMENT

Brooks, Hon. Jack, a Representative in Congress from the State of Texas, and chairman, Subcommittee on Economic and Commercial Law	1
--	---

WITNESSES

Delmer, Dr. Merle W., chair, council on legislation, American Medical Association	73
McGlothlen, Scott, American Association of Nurse Anesthetists	102
McMillan, Hon. J. Alex, a Representative in Congress from the State of North Carolina	18
Metzenbaum, Hon. Howard M., a Senator in Congress from the State of Ohio	12
O'Neil-White, Alphonso, vice president and general counsel, Group Health Association of America, Inc.	123
Steptoe, Mary Lou, Acting Director, Bureau of Competition, Federal Trade Commission	29
Traw, Kelly, manager, public policy, Washington Business Group on Health ...	143

LETTERS, STATEMENTS, ETC., SUBMITTED FOR THE HEARING

Delmer, Dr. Merle W., chair, council on legislation, American Medical Association: Prepared statement	75
McGlothlen, Scott, American Association of Nurse Anesthetists: Prepared statement	105
McMillan, Hon. J. Alex, a Representative in Congress from the State of North Carolina: Prepared statement	21
Metzenbaum, Hon. Howard M., a Senator in Congress from the State of Ohio: Prepared statement	15
O'Neil-White, Alphonso, vice president and general counsel, Group Health Association of America, Inc.: Prepared statement	126
Steptoe, Mary Lou, Acting Director, Bureau of Competition, Federal Trade Commission: Prepared statement	32
Traw, Kelly, manager, public policy, Washington Business Group on Health: Prepared statement	145

APPENDIXES

Appendix 1.—Material submitted with the prepared statement of Mary Lou Steptoe, Acting Director, Bureau of Competition, Federal Trade Commission	173
Press release—FTC News, September 15, 1993, Federal Trade Commission, Justice Department Announce Joint Policies for Health-Care Antitrust Enforcement	173

IV

	Page
Press release—Department of Justice, September 15, 1993, Antitrust Enforcement Policy Statements Issued for Health Care Industry	176
U.S. Department of Justice and the Federal Trade Commission: Statements of Antitrust Enforcement Policy in the Health Care Area, September 15, 1993	186
Appendix 2.—Material submitted for the hearing record	233
Alliance of American Insurers, American Council of Life Insurance, National Association of Independent Insurers, National Association of Life Underwriters, National Association of Mutual Insurance Companies, National Association of Professional Insurance Agents, Reinsurance Association of America, Coalition for a Competitive Insurance Market: June 15, 1994, statement	233
American College of Nurse-Midwives: June 15, 1994, statement	236
American Health Care Association: June 15, 1994, statement	244
American Hospital Association: June 16, 1994, letter from Rick Pollack, executive vice-president, Federal relations, to Chairman Brooks and accompanying January 28, 1994, letter from Frederic J. Entin, senior vice president and general counsel, American Hospital Association, to Anne K. Bingaman, Assistant Attorney General, Antitrust Division, Department of Justice	248
American Nurses Association: June 24, 1994, statement	275
Department of Justice: June 15, 1994, statement of Anne K. Bingaman, Assistant Attorney General, Antitrust Division	288
Home Health Services and Staffing Association: June 29, 1994, statement of James C. Pyles, counsel	300
National Kidney Cancer Association: June 15, 1994, statement of Eugene P. Schonfeld, president and chief executive officer	306

HEALTH SECURITY ACT—ANTITRUST PROVISIONS

WEDNESDAY, JUNE 15, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2141, Rayburn House Office Building, Hon. Jack Brooks (chairman of the subcommittee) presiding.

Present: Representatives Jack Brooks, Mike Synar, Howard L. Berman, David Mann, Hamilton Fish, Jr., Elton Gallegly, Charles T. Canady, Bob Inglis, Bob Goodlatte, and Carlos J. Moorhead.

Staff present: Cynthia W. Meadow, counsel; George P. Slover, assistant counsel; Perry Apelbaum, assistant counsel; Carrie Bedwell Mann, assistant counsel; Catherine S. Cash, research assistant; Deloris L. Cole, office manager; full committee: Jonathan R. Yarowsky, general counsel; Alan F. Coffey, minority chief counsel; Charles E. Kern II, minority counsel; and Bryan Frazier and Michael McGown, interns.

OPENING STATEMENT OF CHAIRMAN BROOKS

Mr. BROOKS. The subcommittee will come to order.

Today, we will hold our first hearing on the Health Security Act, focusing on health care antitrust issues.

Since President Clinton submitted his ambitious plan for reforming, one-seventh of the American economy, three House committees, and two committees in the Senate have been absorbed in comprehensively reviewing, rethinking, and rewriting it. The Judiciary Committee's jurisdiction over the bill, while not as expansive, nevertheless holds critical implications for the ultimate success of any health care reform initiative and the future well-being of the American people.

While most Americans are busy dissecting the concept of managed competition, some are using the occasion to seek antitrust exemptions. Others, however, warn that the antitrust exemptions would seriously undermine the central goal of health care reform: to bring costs under control and empower the health care consumer in the marketplace.

The assertion that the antitrust laws are too complicated and confusing when applied to this or that particular business is a familiar one. I was pleased that the Justice Department and the FTC rejected the call for exemptions last year, when they issued their joint set of industry-specific antitrust enforcement guidelines for

health care—in itself an unprecedented action. Nevertheless, some continue pressing for exemptions, and there is even one in the Health Security Act—just a little bitty one, some say. Other bills are taking an even more radical approach.

The subcommittee is fortunate to have a distinguished group of witnesses before it today to help us evaluate the role of antitrust in health care. We welcome you all and look forward to your testimony.

[Portions of the bill, H.R. 3600, follow:]

103D CONGRESS
1ST SESSION

H. R. 3600

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 20, 1993

Mr. GEPHARDT (for himself, Mr. BONIOR, Mr. HOYER, Mr. FAZIO, Mrs. KENNELLY, Mr. LEWIS of Georgia, Mr. RICHARDSON, Mr. DINGELL, Mr. ROSTENKOWSKI, Mr. FORD of Michigan, Mr. WAXMAN, Mrs. COLLINS of Illinois, Mr. STARK, Mr. WILLIAMS, Mr. CLAY, Mr. BROOKS, Mr. MOAKLEY, Mr. ABERCROMBIE, Mr. ACKERMAN, Mr. ANDREWS of Maine, Mr. BARRETT of Wisconsin, Mr. BERMAN, Mr. BILBRAY, Mr. BLACKWELL, Mr. BORSKI, Mr. BROWN of California, Ms. BROWN of Florida, Mr. CARDIN, Mr. CLYBURN, Mr. COYNE, Mr. DE LUGO, Ms. DELAURO, Mr. DEUTSCH, Mr. DICKS, Mr. DIXON, Mr. DURBIN, Mr. EDWARDS of California, Mr. ENGEL, Ms. ENGLISH of Arizona, Ms. ESHOO, Mr. FALEOMAVAEGA, Mr. FILNER, Mr. FLAKE, Mr. FOGLIETTA, Mr. FRANK of Massachusetts, Mr. GEJDENSON, Mr. GIBBONS, Mr. HASTINGS, Mr. HILLARD, Mr. HINCHEY, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. JOHNSTON of Florida, Mr. KANJORSKI, Mr. KREIDLER, Mr. LaFALCE, Mr. LANTOS, Mr. LEVIN, Ms. LONG, Mr. MARTINEZ, Mr. MATSUI, Ms. MCKINNEY, Mrs. MEEK, Mr. MINGE, Mrs. MINK, Mr. MURPHY, Mr. MURTHA, Ms. NORTON, Mr. OBERSTAR, Mr. OBEY, Mr. OWENS, Mr. PASTOR, Mr. PAYNE of New Jersey, Mr. RAHALL, Mr. RANGEL, Mr. REYNOLDS, Mr. ROMERO-BARCELÓ, Mr. RUSH, Mr. SABO, Mr. SAWYER, Mr. SCOTT, Mr. SERRANO, Ms. SHEPHERD, Mr. SKAGGS, Ms. SLAUGHTER, Mr. SMITH of Iowa, Mr. STOKES, Mr. STRICKLAND, Mr. STUDDS, Mr. SWIFT, Mr. SYNAR, Mr. THORNTON, Mrs. THURMAN, Mr. TRAFICANT, Mr. UNDERWOOD, Mrs. UNSOELD, Mr. VENTO, Mr. WATT, Mr. WHEAT, Mr. WISE, and Mr. YATES) introduced the following bill; which was referred jointly to the Committee on Energy and Commerce, to the Committee on Ways and Means, and to the Committee on Education and Labor for consideration of such provisions in titles I, III, VI, VIII, X, and XI as fall within its jurisdiction pursuant to clause 1(g) of rule X; and concurrently, for a period ending not later than two weeks after all three committees of joint referral report to the House (or a later time

if the Speaker so designates), to the Committee on Armed Services for consideration of subtitle A of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(c) of rule X, to the Committee on Veterans' Affairs for consideration of subtitle B of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(u) of rule X, to the Committee on Post Office and Civil Service for consideration of subtitle C of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(o) of rule X, to the Committee on Natural Resources for consideration of subtitle D of title VIII and such provisions of title I as fall within its jurisdiction pursuant to clause 1(n) of rule X, to the Committee on the Judiciary for consideration of subtitles C through F of title V and such other provisions as fall within its jurisdiction pursuant to clause 1(l) of rule X, to the Committee on Rules for consideration of sections 1432(d), 6006(f), and 9102(e)(5), and to the Committee on Government Operations for consideration of subtitle B of title V and section 5401

A BILL

To ensure individual and family security through health care coverage for all Americans in a manner that contains the rate of growth in health care costs and promotes responsible health insurance practices, to promote choice in health care, and to ensure and protect the health care of all Americans.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3

1 SECTION 1. SHORT TITLE; TABLE OF TITLES AND SUB-
2 TITLES.

3 (a) SHORT TITLE.—This Act may be cited as the
4 “Health Security Act”.

131

1 uals shall be enrolled in other applicable health plans
2 effective on such date.

3 (e) NOTICE TO BOARD.—If an election with respect
4 to a corporate alliance is terminated pursuant to sub-
5 section (a) or subsection (b), the Secretary of Labor shall
6 notify the National Health Board of the termination of
7 the election.

8 **PART 2—GENERAL RESPONSIBILITIES AND**
9 **AUTHORITIES OF REGIONAL ALLIANCES**

10 **SEC. 1321. CONTRACTS WITH HEALTH PLANS.**

11 (a) CONTRACTS WITH PLANS.—

12 (1) IN GENERAL.—In order to assure the avail-
13 ability of the comprehensive benefit package to eligi-
14 ble individuals residing in the alliance area in a cost-
15 effective manner, except as provided in this section,
16 each regional alliance shall negotiate with any will-
17 ing State-certified health plan to enter into a con-
18 tract with the alliance for the enrollment under the
19 plan of eligible individuals in the alliance area. Sub-
20 ject to paragraph (2), a regional alliance shall not
21 enter into any such contract with a health plan that
22 is not a State-certified health plan.

23 (2) TREATMENT OF CERTAIN PLANS.—Each re-
24 gional alliance shall enter into a contract under this
25 section with any veterans health plan of the Depart-

132

1 ment of Veterans Affairs and with a Uniformed
 2 Services Health Plan of the Department of Defense,
 3 that offers the comprehensive benefit package to eli-
 4 gible individuals residing in the alliance area if the
 5 appropriate official requests to enter into such a
 6 contract.

7 (b) GENERAL CONDITIONS FOR DENIAL OF CON-
 8 TRACT BY A REGIONAL ALLIANCE.—A regional alliance
 9 is not required under this section to offer a contract with
 10 a health plan if—

11 (1) the alliance finds that the proposed bid ex-
 12 ceeds 120 percent of the regional alliance per capita
 13 ppremium target (as determined under section
 14 6003); or

15 (2) the plan has failed to comply with require-
 16 ments under prior contracts with the alliance, in-
 17 cluding failing to offer coverage for all the services
 18 in the comprehensive benefit package in the entire
 19 service area of the plan.

20 SEC. 1322. OFFERING CHOICE OF HEALTH PLANS FOR EN-
 21 ROLLMENT; ESTABLISHMENT OF FEE-FOR-
 22 SERVICE SCHEDULE.

23 (a) IN GENERAL.—Each regional alliance must pro-
 24 vide to each eligible enrollee (as defined in section
 25 1902(14)) with respect to the alliance a choice of health

133

1 plans among the plans which have contracts in effect with
2 the alliance under section 1321 (in the case of a regional
3 alliance) or section 1341 (in the case of a corporate alli-
4 ance).

5 (b) OFFERING OF PLANS BY REGIONAL ALLI-
6 ANCES.—

7 (1) IN GENERAL.—Each regional alliance shall
8 include among its health plan offerings at least one
9 fee-for-service plan (as defined in paragraph (2)).

10 (2) FEE-FOR-SERVICE PLAN DEFINED.—

11 (A) IN GENERAL.—For purposes of this
12 Act, the term “fee-for-service plan” means a
13 health plan that—

14 (i) provides coverage for all items and
15 services included in the comprehensive ben-
16 efit package that are furnished by any law-
17 ful health care provider of the enrollee’s
18 choice, subject to reasonable restrictions
19 (described in subparagraph (B)), and

20 (ii) makes payment to such a provider
21 without regard to whether or not there is
22 a contractual arrangement between the
23 plan and the provider.

24 (B) REASONABLE RESTRICTIONS DE-
25 SCRIBED.—The reasonable restrictions on cov-

134

1 erage permitted under a fee-for-service plan (as
 2 specified by the National Health Board) are as
 3 follows:

4 (i) Utilization review.

5 (ii) Prior approval for specified serv-
 6 ices.

7 (iii) Exclusion of providers on the
 8 basis of poor quality of care, based on evi-
 9 dence obtainable by the plan.

10 Clause (ii) shall not be construed as permitting
 11 a plan to require prior approval for non-pri-
 12 mary health care services through a gatekeeper
 13 or other process.

14 (c) ESTABLISHMENT OF FEE-FOR-SERVICE SCHED-
 15 ULE.—

16 (1) IN GENERAL.—Except in the case of re-
 17 gional alliances of a State that has established a
 18 Statewide fee schedule under paragraph (3), each re-
 19 gional alliance shall establish a fee schedule setting
 20 forth the payment rates applicable to services fur-
 21 nished during a year to individuals enrolled in fee-
 22 for-service plans (or to services furnished under the
 23 fee-for-service component of any regional alliance
 24 health plan) for use by regional alliance health plans
 25 under section 1406(c) and corporate alliance health


1 plans providing services subject to the schedule in
2 the regional alliance area.

3 (2) NEGOTIATION WITH PROVIDERS.—The fee
4 schedule under paragraph (1) shall be established
5 after negotiations with providers, and (subject to
6 paragraphs (5) and (6)) providers may collectively
7 negotiate the fee schedule with the regional alliance.

8 (3) USE OF STATEWIDE SCHEDULE.—At the
9 option of a State, the State may establish its own
10 statewide fee schedule which shall apply to all fee-
11 for-service plans offered by regional alliances and
12 corporate alliances in the State instead of alliance-
13 specific schedules established under paragraph (1).

14 (4) ANNUAL REVISION.—A regional alliance or
15 State (as the case may be) shall annually update the
16 payment rates provided under the fee schedule es-
17 tablished pursuant to paragraph (1) or paragraph
18 (3).

19 (5) ACTIVITIES TREATED AS STATE ACTION OR
20 EFFORTS INTENDED TO INFLUENCE GOVERNMENT
21 ACTION.—The establishment of a fee schedule under
22 this subsection by a regional alliance of a State shall
23 be considered to be pursuant to a clearly articulated
24 and affirmatively expressed State policy to displace
25 competition and to be actively supervised by the



1 State, and conduct by providers respecting the es-
2 tablishment of the fee schedule, including collective
3 negotiations by providers with the regional alliance
4 (or the State) pursuant to paragraph (2), shall be
5 considered as efforts intended to influence govern-
6 mental action.

7 (6) NO BOYCOTT PERMITTED.—Nothing in this
8 subsection shall be construed to permit providers to
9 threaten or engage in any boycott.

10 (7) NEGOTIATIONS DEFINED.—In this sub-
11 section, “negotiations” are the process by which pro-
12 viders collectively and jointly meet, confer, consult,
13 discuss, share information, among and between
14 themselves in order to agree on information to be
15 provided, presentations to be made, and other such
16 activities with respect to regional alliances (or
17 States) relating to the establishment of the fee
18 schedule (but not including any activity that con-
19 stitutes engaging in or threatening to engage in a
20 boycott), as well as any and all collective and joint
21 meetings, discussions, presentations, conferences,
22 and consultations between or among providers and
23 any regional alliance (or State) for the purpose of
24 establishing the fee schedule described in this sub-
25 section.

Mr. BROOKS. This morning the first group will consist of congressional witnesses. Our first witness is my friend and colleague, Senator Howard Metzenbaum, a distinguished Senator from the great State of Ohio. He is also chairman of our Senate counterpart, the Subcommittee on Antitrust, Monopolies, and Business Rights of the Senate Judiciary Committee.

After that we will hear from Congressman Alex McMillan of Charlotte, NC, the Republican Member from the Ninth Congressional District of North Carolina, with a lovely wife. As a member of the Committee on Energy and Commerce and its Subcommittee on Health and Environment, Mr. McMillan has had a special interest in health care reform, and has introduced a bill to provide antitrust exemptions in certain instances.

Gentlemen, we appreciate your being with us. We ask that you make your comments in 5 minutes or so. Your complete written statements will of course be included in the record.

Senator Metzenbaum, we are pleased to hear from you, sir.

STATEMENT OF HON. HOWARD METZENBAUM, A SENATOR IN CONGRESS FROM THE STATE OF OHIO

Mr. METZENBAUM. Mr. Chairman, it is a privilege to appear before you, and I truly mean that. It will probably be the last time I have a chance to appear before you before I leave the Congress. But you have been a wonderful chairman and it has been a privilege to work with you. You have provided great leadership with respect to protecting the antitrust laws of this country.

Your recent activity in connection with the insurance industry and McCarran-Ferguson was an absolutely superb undertaking, and I hope we can complete that action on the Senate side. You have been a leader in the telecommunications area. I consider you a good friend. And I think that it is a real privilege for me to be here with you today.

I think you know I am committed to tough antitrust enforcement because it protects the consumers from price-gouging cartels and abusive monopoly. That is true whether the industry is insurance or ocean shipping or health care.

As you will hear this morning, consumers have been gouged by price-fixing doctors and hospitals, and even worse, they have been denied care as a result of provider boycotts over fees. The fact is that antitrust concessions or exemptions for providers would completely undermine the cost-saving goals of health reform and threaten consumers.

I strongly urge you to follow the example set by the Senate Labor Human Resources Committee last week. That committee, of which I am a member, is chaired by Senator Kennedy. It reported a bill that does not include a single antitrust exemption for doctors' or hospitals, and repeals McCarran-Ferguson immunity.

If there ever was an antitrust problem in the health care industry, the Department of Justice and the Federal Trade Commission dealt with it last September when they published health care guidelines. I am frank to say I had urged both agencies to develop those guidelines. The agencies responded quickly, and the American Hospital Association cooperated with us in bringing about a

result that accommodated the hospitals' concerns without breaking down the competitive protections of strong antitrust law.

The American Hospital Association publicly indicated its appreciation. The guidelines address the doctors' and the hospitals' most pressing questions and promise a 90-day review of their health care deals. So far, in the short period that has passed since that time, 11 deals have been reviewed under this procedure, and none have been challenged. Frankly, I don't know of any Federal agency that has been as responsive to the legitimate concerns of doctors and hospitals as the antitrust agencies.

However, I oppose antitrust exemptions for health care providers, including those in the administration's reform bill and the bill sponsored by Representative Archer. Although I am a cosponsor of the administration health care bill, I made it very clear to the President's wife, Hillary Rodham Clinton, that if that remained in, I would not support their bill.

Although the exemptions in the bills differ, both would permit doctors and other providers to fix prices and boycott patients. The exemptions in the administration's Health Security Act give doctors and other providers blanket antitrust immunity to collude on prices and then negotiate those prices in order to develop a payment schedule.

Although the exemption might appear limited, I believe that it would increase the cost of health care for consumers under both fee-for-service and managed care plans. And we shouldn't permit that to occur.

I am not alone in this view. An extraordinary coalition of groups, including the American Association of Retired Persons, the Consumer Federation of America, the America Nurses Association, the Federation of American Health Systems, the Group Health Association of America, and the major health insurance companies, join me in opposing those exemptions.

Frankly, I don't believe there is one other health issue on which all of these groups could agree except antitrust. The only group in the health care industry that is not represented in the coalition is the doctors. That is because the AMA has made winning antitrust exemption its number-one legislative priority.

The so-called antitrust relief or clarification that the AMA is asking for may sound modest. I tell you that it is not. To quote an April 11 U.S. News and World Report article, "The changes that the AMA seeks sound like legal minutia, but they represent major departures from current antitrust law."

I am frank to say, Mr. Chairman, I urge you and this committee to reject the AMA position. Make no mistake: Allowing doctors, hospitals or other providers to include and fix prices is bad medicine for consumers.

Although the hospitals are not here requesting an exemption, let me give you an example of how collusion can and has in the past raised prices.

Independence Blue Cross of Philadelphia told the Antitrust Division that its costs were \$57 million higher when the State required it to negotiate prices with a large group of hospitals. The company estimated that in 5 years it would save over \$500 million from individual negotiations.

The antitrust exemption in Representative Archer's bill, and its mirror image sponsored by Representative Thomas, would also raise prices for consumers. I am not familiar with Representative McMillan's bill. However, the Consumer Coalition has opposed the Thomas bill. The Department of Justice has also opposed them on the grounds that they are "unnecessary and potentially harmful."

The Federal Trade Commission has taken a similar position, warning that the bill would "immunize egregious anticompetitive conduct harmful to consumers."

The fact is the exemptions in the Archer bill would create price-fixing medical cartels and would immunize health care deals that the Justice Department failed to block in 90 days. If they didn't act in 90 days, they would have no further jurisdiction. They would also require the Justice Department to get clearance from the Department of Health and Human Services before approving a health care deal, which it isn't very likely to be able to do within 90 days. They would encourage costly Federal court appeals by disappointed applicants for antitrust immunities. And they would reduce antitrust penalties for anticompetitive joint ventures. Other than that, they are OK, probably.

To be frank, I would be more sympathetic to the doctors' pleas if they could show me those laws block procompetitive deals that benefit consumers. Neither I nor the American people would support antitrust exemptions if they created medical cartels which could increase prices and/or boycott patients.

For now, I am convinced that the only change we need to make in the antitrust laws to speed health reform is to revoke the McCarran-Ferguson exemption for health insurers, which the Senate Labor Committee did last week. That change would prevent insurance companies from fixing the price and terms of health care coverage.

I know that you, Mr. Chairman, have negotiated a broad compromise to reform McCarran-Ferguson immunity for the entire insurance industry. I think that was a superb undertaking, and I intend to support you in that effort vigorously.

However, until a comprehensive McCarran-Ferguson reform is passed, I urge you to include the repeal for health insurance in the committee's health reform bill.

Mr. Chairman, I appreciate the opportunity to appear before you and stand prepared to respond to questions.

[The prepared statement of Mr. Metzenbaum follows:]

U.S. Senator Howard M.

METZENBAUM

of Ohio

Committees
Judiciary
Labor and Human Resources
Select Committee on Intelligence
Environment and Public Works

Chairmanships
Subcommittee on Antitrust
Subcommittee on Labor

STATEMENT OF HOWARD M. METZENBAUM
CHAIRMAN, SENATE JUDICIARY COMMITTEE
SUBCOMMITTEE ON ANTITRUST,
MONOPOLIES & BUSINESS RIGHTS
AT THE HOUSE JUDICIARY
COMMITTEE'S HEARING ON
HEALTH CARE AND ANTITRUST
JUNE 15, 1994

CHAIRMAN BROOKS, AND MEMBERS OF THE COMMITTEE, THANK YOU FOR INVITING ME TO APPEAR BEFORE YOU TODAY. AS YOU KNOW, I AM COMMITTED TO TOUGH ANTITRUST ENFORCEMENT BECAUSE IT PROTECTS CONSUMERS FROM PRICE-GOUGING CARTELS AND ABUSIVE MONOPOLIES. THAT'S TRUE WHETHER THE INDUSTRY IS INSURANCE OR OCEAN SHIPPING OR HEALTH CARE. AS YOU WILL HEAR THIS MORNING, CONSUMERS HAVE BEEN GOUGED BY PRICE-FIXING DOCTORS AND HOSPITALS AND -- EVEN WORSE -- DENIED CARE AS A RESULT OF PROVIDER BOYCOTTS OVER FEES.

THE FACT IS THAT ANTITRUST CONCESSIONS OR EXEMPTIONS FOR PROVIDERS WOULD COMPLETELY UNDERMINE THE COST SAVINGS GOAL OF HEALTH REFORM. THEREFORE, I URGE YOU TO FOLLOW THE EXAMPLE SET BY SENATE LABOR AND HUMAN RESOURCES COMMITTEE LAST WEEK. THAT COMMITTEE, OF WHICH I AM A MEMBER, REPORTED A BILL THAT DOES NOT INCLUDE A SINGLE ANTITRUST EXEMPTION FOR DOCTORS OR HOSPITALS AND REPEALS MCCARRAN-FERGUSON IMMUNITY FOR HEALTH INSURERS.

IF THERE EVER WAS AN ANTITRUST PROBLEM IN THE HEALTH CARE INDUSTRY, THE DEPARTMENT OF JUSTICE AND THE FEDERAL TRADE COMMISSION ("FTC") DEALT WITH IT LAST SEPTEMBER WHEN THEY PUBLISHED HEALTH CARE GUIDELINES. I HAD URGED BOTH AGENCIES TO DEVELOP THOSE GUIDELINES. THE HOSPITALS COOPERATED IN BRINGING ABOUT A RESULT THAT ACCOMMODATED THEIR CONCERNS WITHOUT BREAKING DOWN THE PROCOMPETITIVE ASPECTS OF STRONG ANTITRUST PROTECTION. THE AMERICAN HOSPITAL ASSOCIATION INDICATED ITS APPRECIATION FOR MY LEADERSHIP.

THE GUIDELINES ADDRESS THE DOCTORS' AND THE HOSPITALS' MOST PRESSING QUESTIONS AND PROMISE A 90-DAY REVIEW OF THEIR HEALTH CARE DEALS. SO FAR, 11 DEALS HAVE BEEN REVIEWED UNDER THIS PROCEDURE AND NONE HAVE BEEN CHALLENGED. FRANKLY, I DON'T KNOW OF ANY FEDERAL AGENCIES THAT HAVE BEEN AS RESPONSIVE TO THE LEGITIMATE CONCERNS OF DOCTORS AND HOSPITALS.

HOWEVER, I AM OPPOSED TO ANTITRUST EXEMPTIONS FOR HEALTH CARE PROVIDERS, INCLUDING THOSE IN THE ADMINISTRATION'S REFORM BILL AND THE BILL SPONSORED BY REPRESENTATIVE ARCHER, H.R. 3486. ALTHOUGH THE EXEMPTIONS IN THE BILLS DIFFER, BOTH WOULD PERMIT DOCTORS AND OTHER PROVIDERS TO FIX PRICES AND BOYCOTT PATIENTS.

THE EXEMPTION IN THE HEALTH SECURITY ACT GIVES DOCTORS AND OTHER PROVIDERS BLANKET ANTITRUST IMMUNITY TO COLLUDE ON PRICES AND THEN "NEGOTIATE" THOSE PRICES IN ORDER TO DEVELOP A PAYMENT SCHEDULE. ALTHOUGH THE EXEMPTION MIGHT APPEAR LIMITED, I BELIEVE THAT IT WOULD INCREASE THE COST OF HEALTH CARE FOR CONSUMERS UNDER BOTH FEE-FOR-SERVICE AND MANAGED CARE PLANS.

I AM NOT ALONE IN THIS VIEW. AN EXTRAORDINARY COALITION OF GROUPS, INCLUDING THE AMERICAN ASSOCIATION OF RETIRED PERSONS, THE CONSUMER FEDERATION OF AMERICA, THE AMERICAN NURSES ASSOCIATION, THE FEDERATION OF AMERICAN HEALTH SYSTEMS, THE GROUP HEALTH ASSOCIATION OF AMERICA AND THE MAJOR HEALTH INSURANCE COMPANIES IS OPPOSING THOSE EXEMPTIONS. FRANKLY, I DON'T BELIEVE THERE IS ONE OTHER HEALTH ISSUE ON WHICH ALL OF THESE GROUPS COULD AGREE EXCEPT ANTITRUST.

THE ONLY GROUP IN THE HEALTH CARE INDUSTRY THAT IS NOT REPRESENTED ON THE COALITION IS THE DOCTORS. THAT IS BECAUSE THE AMA HAS MADE WINNING ANTITRUST CONCESSIONS ITS NUMBER ONE LEGISLATIVE PRIORITY. THE SO-CALLED ANTITRUST "RELIEF" OR "CLARIFICATION" THAT THE AMA IS ASKING FOR MAY SOUND MODEST. IT IS NOT. TO QUOTE AN APRIL 11TH U.S. NEWS & WORLD REPORT ARTICLE, "THE CHANGES THAT THE AMA SEEKS SOUND LIKE LEGAL MINUTIAE, BUT THEY REPRESENT MAJOR DEPARTURES FROM CURRENT [ANTITRUST] LAW." I URGE YOU TO REJECT THEM.

MAKE NO MISTAKE, ALLOWING DOCTORS, HOSPITALS OR OTHER PROVIDERS TO COLLUDE AND FIX PRICES IS BAD MEDICINE FOR CONSUMERS. ALTHOUGH THE HOSPITALS ARE NOT HERE REQUESTING ANTITRUST EXEMPTIONS, LET ME GIVE YOU AN EXAMPLE OF HOW COLLUSION CAN RAISE PRICES. INDEPENDENCE BLUE CROSS OF PHILADELPHIA TOLD THE ANTITRUST DIVISION THAT ITS COSTS WERE \$57 MILLION HIGHER WHEN THE STATE REQUIRED IT TO NEGOTIATE PRICES WITH A LARGE GROUP OF HOSPITALS. THE COMPANY ESTIMATED THAT IN FIVE YEARS IT WOULD SAVE OVER \$500 MILLION FROM INDIVIDUAL NEGOTIATIONS.

THE ANTITRUST EXEMPTIONS IN REPRESENTATIVE ARCHER'S BILL, AND IT'S MIRROR IMAGE SPONSORED BY REPRESENTATIVE THOMAS, H.R. 3704, WOULD ALSO RAISE PRICES FOR CONSUMERS. THE COALITION I JUST DESCRIBED HAS OPPOSED THE THOMAS EXEMPTIONS, ALONG WITH THE STATE ATTORNEYS GENERAL AND A GROUP OF 24 DISTINGUISHED ANTITRUST LAW PROFESSORS. THE DEPARTMENT OF JUSTICE HAS ALSO OPPOSED THEM ON THE GROUNDS THAT THEY ARE "UNNECESSARY AND POTENTIALLY HARMFUL." THE FEDERAL TRADE COMMISSION HAS TAKEN A SIMILAR POSITION, WARNING THAT THE BILL WOULD "IMMUNIZE EGREGIOUS ANTICOMPETITIVE CONDUCT HARMFUL TO CONSUMERS."

THE FACT IS THAT THE EXEMPTIONS IN THE ARCHER BILL WOULD:

- CREATE PRICE FIXING MEDICAL CARTELS;
- IMMUNIZE HEALTH CARE DEALS THAT THE JUSTICE DEPARTMENT FAILED TO BLOCK IN 90 DAYS;
- REQUIRE THE JUSTICE DEPARTMENT TO GET CLEARANCE FROM THE DEPARTMENT OF HEALTH AND HUMAN SERVICES BEFORE APPROVING A HEALTH CARE DEAL;
- ENCOURAGE COSTLY FEDERAL COURT APPEALS BY DISAPPOINTED APPLICANTS FOR ANTITRUST IMMUNITY; AND
- REDUCE ANTITRUST PENALTIES FOR ANTICOMPETITIVE JOINT VENTURES.

TO BE FRANK, I WOULD BE MORE SYMPATHETIC TO THE DOCTORS' PLEAS FOR ANTITRUST RELIEF IF THEY COULD SHOW ME THAT THOSE LAWS BLOCKED PROCOMPETITIVE DEALS THAT WOULD BENEFIT CONSUMERS. NEITHER I NOR THE AMERICAN PEOPLE WOULD SUPPORT ANTITRUST EXEMPTIONS THAT CREATED MEDICAL CARTELS WHICH COULD INCREASE PRICES AND BOYCOTT PATIENTS.

FOR NOW, I AM CONVINCED THAT THE ONLY CHANGE THAT WE NEED TO MAKE IN THE ANTITRUST LAWS TO SPEED HEALTH REFORM IS TO REVOKE THE MCCARRAN-FERGUSON EXEMPTION FOR HEALTH INSURERS, WHICH THE SENATE LABOR COMMITTEE DID LAST WEEK. THAT CHANGE WOULD PREVENT INSURANCE COMPANIES FROM FIXING THE PRICE AND THE TERMS OF HEALTH CARE COVERAGE.

I KNOW THAT YOU, MR. CHAIRMAN, HAVE NEGOTIATED A BROAD COMPROMISE TO REFORM MCCARRAN-FERGUSON IMMUNITY FOR THE ENTIRE INSURANCE INDUSTRY. I APPLAUD YOU FOR THAT EFFORT AND I INTEND TO SUPPORT IT VIGOROUSLY. HOWEVER, UNTIL COMPREHENSIVE MCCARRAN-FERGUSON REFORM IS PASSED, I URGE YOU TO INCLUDE THE REPEAL FOR HEALTH INSURANCE IN THE COMMITTEE'S HEALTH REFORM BILL.

Mr. BROOKS. Thank you very much, Senator.

You have been a battler for antitrust and people's rights for a lot of years. We are going to miss you. We will try to figure out another way to get you back over here before you go back to work for your son-in-law to succeed you.

Mr. McMillan, the gentleman from North Carolina.

STATEMENT OF HON. ALEX McMILLAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. McMILLAN. Thank you, Mr. Chairman. I appreciate the opportunity to testify before you today. I guess I should add—and I mean this—that you, too, have a lovely wife.

Mr. METZENBAUM. Mine's OK too.

Mr. McMILLAN. I am sure that everybody's wife is lovely.

Mr. BROOKS. It is not difficult for people like us to out-marry ourselves.

Mr. McMILLAN. I appreciate your leadership on this committee, and on this important issue.

As we all know, there are some crucial legal issues interrelated with health care reform, one of them being antitrust, the other being malpractice reform. And feeling about these issues is strong.

I have entered legislation on both respects and am pleased to testify with respect to the antitrust bill that I introduced here today. I am not sure it is that much in conflict with what the Senator referred to, because frankly this bill was introduced well over a year ago, and I think some of the rulings by the Justice Department and the FTC may have partially addressed some of the issues that I was concerned about.

I think concerns about antitrust laws are widely shared by many of our colleagues, because most of our serious attempts at health care reform have addressed the issue of monopolies in medical care. I think that is either in the form of trying to eliminate them or in the form of trying to establish them.

Most of us recognize that one of the major cost drivers in our system, and any health care reform that is serious has to deal with the cost drivers, is what we call the overcapitalization and distorted staffing of health care services. Redundant equipment and redundant people that add costs onto the system that have to be passed on to us, the consumers.

What we really have in health care today is the competition of services, and not a competition of price. Admittedly that is difficult to achieve when we already have enormous consolidation of providers in most any community in the country, and in most cases, completely consolidating.

One of the major elements of health care reform should be to introduce competition into the marketplace, which in many cases does not now exist. We are attempting to do that by basically creating competitive buyers with leverage.

I think the President's proposal tries to do that, although it overly consolidates it, in my judgment. Other bills are attempting to do this by allowing easy formation of groups with sufficient leverage to exercise negotiating leverage on providers.

In many communities, that is already happening. So to simply talk about this as if it were any other kind of competition is not realistic.

What we need to do is to open up the system to achieve cost-effective combinations that are in the public interest, not contrary to the public interest.

Recently, the Wall Street Journal wrote an article concerning the gamma knife, a \$3 million surgical tool that was developed to treat a relatively small segment of the population. Because of this, cost of the service is extraordinarily high.

So operating within an economy of scale is extremely important. One would think that hospitals would logically say, "Well, okay, let's just get one, and we will joint venture this thing, and therefore we will be able to operate it at a lower cost for the community." This was not the case that occurred in Fort Lauderdale.

So we had two hospitals that—and frequently in a community like this where you have two or three hospitals, they basically are in technological competition and service competition and not price competition—ended up buying a gamma knife.

Both ended up investing \$3 million. And largely that is because the antitrust laws are written in such a way that would not have allowed them to joint venture such an operation, and therefore reduce the cost dramatically to the consumer. These hospitals were within 10 miles of one another.

I could cite hundreds of cases that are comparable with that, and I think you can probably find them within your own community. In my own community of Charlotte, for example, which is an urban center of a metro population of about a million and a quarter with a central city of half a million, three major hospitals, all of which are fairly sophisticated, a lot of the real cost reduction can occur through combination of efforts. They don't all have to do heart bypass. They don't all have to do heart transplants. You don't have to have a CAT scanner in every regional hospital in the area. Combinations can achieve a lot of this. That is really the intent of my legislation.

In an environment of insufficient direction from Federal agencies, which preexisted the introduction of my bill, hospitals and providers were running scared of these sorts of cost-effective combinations, and with good reason.

In many cases they were being taken to court with exorbitant legal expenses. So the safest thing to do was to do nothing. Perhaps the rulings by the Justice Department have modified that somewhat. I think that is something that I would submit that the committee should examine very carefully.

If those rulings have in fact allowed the kinds of waivers under very controlled circumstances that would be allowed for the benefit of the consumer and only for the benefit of the consumer, not for the benefit of price fixing or creating monopolies, then that would be acceptable.

As I said, most of the approaches before Congress to health care reform do include antitrust legislation. I am not going to try to defend the others. But basically what my bill, which is known as H.R. 2640, was suggesting was a process of preclearance in which the

Department of Justice and Health and Human Services could provide expedited preclearance or to receive total exemption on an approved plan within 90 days if that provider met the specific guidelines set out by those two Departments.

We are not allowing an open-ended waiver of the antitrust laws. Antitrust laws would still apply, except in very specific cases. And I would urge you to look at those carefully, because if we don't successfully address the cost drivers in health care reform, we are not going to have the resources to deal with the problem.

And I would respectfully urge that this is—along with malpractice reform, controversial as it may be—is absolutely essential to successful health care reform.

I would like to conclude, Mr. Chairman, by asking that a little more extensive description of my proposed legislation, which appeared—

Mr. BROOKS. Without objection.

Mr. McMILLAN. Thank you, Mr. Chairman. I yield back the time you have allotted me.

[The prepared statement of Mr. McMillan follows:]

Opening Statement of
The Honorable Alex McMillan before
the Committee on the Judiciary
15 June 1994

Thank you, Mr. Chairman. I appreciate the opportunity to testify before the Judiciary Committee today concerning antitrust reform. I strongly believe, as do many of our colleagues, that antitrust reform must be included in any discussion of overall health care reform.

Most of us who have been involved in the health care debate realize that one of the major cost drivers in our system is the overcapitalization and distorted staffing of health care services. What we have is competition in services without competition in price. One of the major goals of health care reform should be to introduce competition into the marketplace, and in so doing create more efficient

providers. Making the anti-trust rules clear and predictable will go a long way to do just that.

Just recently, the Wall Street Journal wrote an article concerning the Gamma Knife, a \$3 million surgical tool that was developed to treat a very small population of people. Because of these facts, the charges to use it are extremely high. With an economy of scale so low for this product, one would think that most of the hospitals in the region would pool their resources to lease one.

This was not the case, however, as hospitals became involved in a "technological arms race," each struggling to come up with enough money to buy a Gamma Knife, and therefore stay competitive within the market. If our anti-trust regulations were

written in such a way that it would encourage cost-sharing and other forms of joint ventures, perhaps this would not have happened. Instead, there are now two extremely expensive, limited use machines LESS THAN 10 MILES APART that will inevitably be underutilized. Nevertheless, this redundant cost of amortizing two underutilized machines will be passed on to consumers. While this is only an example, it is certainly not a limited one. There have been thousands of cases where hospitals and other providers have been unable to form joint ventures to share expensive new technologies. The same can be said for redundant computers and specialty staffs. In fact, cost effective combinations on a regional basis are a key to dramatic gains in cost reduction.

Because of insufficient direction from federal agencies, even after the much-ballyhooed change in regulations offered by Deputy Attorney General Anne Bingeman, there has been a real hesitation to do cost sharing arrangements when it comes to capital investment or staffing. Furthermore, the threat of treble damages, and the cost of hiring attorneys should a cause of action be brought by either an individual of the government alleging antitrust, has combined to form a "chilling effect" that really discourages new, innovative arrangements between health care providers.

Most of the health care reform plans currently before Congress address the antitrust issue, although their approaches vary somewhat. In general, I believe that any legislation should include clear,

unambiguous "safe harbors" which would protect providers who join together to form mergers or other joint ventures. My own bill, H.R. 2640, would allow the provider who wished to enter into some type of joint venture the opportunity to receive from DoJ and HHS expedited "preclearance," or to receive a total exemption within 90 days if that provider met the specific guidelines set out by those two departments.

In closing, I would urge this Committee to recognize the need the market has for clear guidelines regarding mergers, innovative new cost-sharing arrangements, and other types of competitive designs that will reduce the cost and increase the quality to consumers.

The criteria for providing "safe harbors" gives full recognition to the distinct possibility that such combinations could work against the public interest. The language of the bill requires not only a demonstration of the benefits to the public but a means of assuring that such benefits continue to accrue.

Any Health Care reform that fails to address the real cost drivers will fail to produce the desired results. Antitrust Reform is one essential to that objective.

Antitrust fears hobble hospitals

■ Antitrust laws, designed to protect consumers, sometimes have opposite effect in health care.

By REP. ALEX McMILLAN
Special To The Observer

The purpose of antitrust law is to protect the public from business arrangements that restrict the choices available to consumers and lead to unrestrained price increases. In the health care field, however, consumers would benefit from the efficiencies that could be generated by increased collaboration between providers. But concerns about possible antitrust violations discourage many health care providers from considering such efforts.



McMillan

Insufficient direction from federal agencies, the threat of treble damages, confusion about antitrust laws and the potential high costs — in time and money — of antitrust lawsuits have created a "chilling effect" that discourages innovative arrangements between health care providers.

For example, last month in Raleigh three hospitals launched a joint project to improve health services for school children. According to the chairman of the board of Wake Medical Center, this unprecedented cooperation almost didn't come about because of fear of antitrust laws.

Chilling effect on reform

The federal government sends contradictory signals. The Department of Health and Human Services (HHS) stresses efficient delivery of health care without duplication of services and excess capacity, while the Justice Department and the Federal Trade Commission (FTC) leave wide open the possibility that activities designed to achieve these goals may be at risk under federal antitrust laws.

Federal officials deny there is a problem. They say there have been

few federal government actions against mergers and none against joint ventures. However, the government's actions when it has opposed such efforts have discouraged many health care providers from considering them.

Horror story in Ukiah

Take the case of Ukiah, Calif., for example. It is a rural community with a population of 14,000. In 1988, the 43-bed Ukiah Adventist Hospital and the 51-bed Ukiah General Hospital merged to form the Ukiah Valley Medical Center. During the nine months preceding the merger, Ukiah General lost approximately \$500,000. The hospitals projected that the merger would eliminate duplicative services, administrative functions and related overhead expenses for an annual savings of \$4 million and a one-time savings of \$2.5 million. Since the merger, Ukiah Valley Medical Center's prices have increased less than the average for California hospitals, while the quality of care has improved: For example, a nuclear medical scanner and a catheterization laboratory, not previously available, now serve the community.

The FTC challenged the consolidation. Four years later, an administrative law judge ordered the FTC complaint dismissed — after the hospital had spent \$1.7 million fighting the lawsuit. Not only was this a waste of money which could have been used to provide medical services, it is emblematic of the chilling effect that stifles innovative efforts between health care providers.

I have introduced legislation to address this problem. The Health Care Cooperative Antitrust Protection Act of 1993 would set up clear guidelines for cooperative arrangements and establish a voluntary regulatory process to enable hospitals and other health care providers to enter cooperative ventures knowing that they are not violating antitrust law. The legislation was developed in conjunction with the N.C. Hospital Association, Carolinas Medical Center and Presbiter-

ian Hospital. Cosponsors include N.C. Reps. Howard Coble, Charles Taylor, Tim Valentine, Martin Lancaster, Steve Neal and Eva Clayton.

Under this legislation, health care providers wanting to enter into a cooperative agreement would have three options:

1. Bypass the regulatory process by relying on attorneys to draft an agreement that does not violate antitrust laws.

2. Receive a limited exemption from antitrust suits by passing a 30-day "pre-clearance process," enabling the secretary of HHS and the attorney general to ensure that the proposed joint venture meets minimal requirements.

3. Receive a total exemption from liability by adhering to guidelines promulgated by HHS and the Justice Department; the exemption could be withdrawn, however, if the joint venture did not continue to comply with the guidelines.

Providers that use the partial or full exemption would be required to file annual reports, specifying what the joint venture has accomplished, to ensure accountability and protect consumers.

Public still protected

Of course, a total exemption from antitrust laws would grant providers exceptional power to determine price and availability of health care. This legislation includes checks on that power. And HHS and the Justice Department would be empowered to revoke the exemption if the provider didn't maintain the requirements for the joint venture.

Legislation to remove uncertainty about antitrust violations will encourage health care providers to enter into joint ventures, consolidations and collaborative efforts that will reduce excess capacity and duplication of services and improve quality of treatment. The public would reap the benefits.

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Rep. Alex McMillan of Charlotte serves on the Health and Environment Subcommittee of Energy and Commerce and the Republican Leaders' Health Care Task Force.

Mr. METZENBAUM. Mr. Chairman, if I may, the points Mr. McMillan made were made a year ago by Senators Rockefeller, Baucus, Daschle, Durenberger, and others. At that time, in a public hearing, I said I assure you we will get this matter resolved at the administrative level. We don't need to change the laws.

And I am happy to tell you that exactly the issue to which you addressed yourself, Congressman, the question of joint use of MRI equipment, the question of joint use of CAT scanners and others, has been addressed by the FTC and the Antitrust Division. They have issued guidelines. The American Hospital Association has publicly commended them and me for my efforts in this direction, and I think that issue is behind us.

There are certainly other remaining issues, but that particular one has really been very well addressed.

Mr. BROOKS. I want to thank you very much for your work on that. We have been concerned about that as well. I think it has been resolved very handily. I don't think there is a bar to the cooperative utilization and acquisition of expensive medical equipment like CAT scanners or the latest image makers. It doesn't guarantee you are going to live, though, Howard.

Mr. MCMILLAN. Mr. Chairman, if I can simply add to that, I don't disagree with what the Senator said. Joint use of CAT scanners is a pretty easy kind of thing to identify. But some of these things get more complex.

For example, joint operations between a central city urban hospital and a rural hospital, you get into issues of combined staff and so forth. And often the redundant costs aren't simply a piece of equipment; they are excess staff that duplicates one to the other.

So I would just simply submit without knowing for sure that this be examined critically and is perhaps worth some further hearing on to see if in fact what the Senator suggests, which may well be the case, is in fact happening.

Mr. BROOKS. We will look at that. There is available now a review process for, as you say, arrangements, et cetera. Informally, I would say that I don't think there is any problem about resolving equipment and joint staff. The problem is price fixing to the detriment of consumers, all of those people who need medical care. If any group of people—doctors, insurance companies, hospital—rigs all the prices, that will create a severe disadvantage to people who are sick.

Now, that is what we have to have a competitive surveillance on. That is what I want the Justice Department to be able to take a look at. If these groups are doing it all on the level, there won't be any problems. But if they rig the prices, then sick people will be disadvantaged, and that is going to be a no-no.

Mr. Fish, did you want to say anything to our distinguished colleagues?

Mr. FISH. I wanted to point out, Mr. Chairman, that over a year ago, Republican Leader Bob Michel, set up a House Republican Task Force on Health Care Reform. The gentleman from North Carolina has been a key figure in the task force and I would like to congratulate him for his excellent work on health care reform issues. His thoughtful approach to antitrust reform, in particular, has been a positive contribution to this entire debate.

We look forward to working with you, Congressman McMillan, in the coming weeks as we fashion this legislation.

Thank you very much.

Mr. BROOKS. Thank you very much, gentlemen.

Mr. METZENBAUM. Thank you, Mr. Chairman.

Mr. BROOKS. This morning I am asking our public witnesses to appear at the witness table in a panel to testify on H.R. 3600.

Ms. Steptoe, Dr. Delmer, Mr. McGlothlen, Mr. O'Neil-White, Ms. Traw, come on up.

Dr. Delmer is a good doctor. He is a very well respected practitioner in Jefferson County for many years.

To save time, I would ask each witness to summarize your statement within 5 minutes. After you have completed your statement, the subcommittee will address questions to all of you in general. All of your statements will be included in their entirety. Every pristine word that you all have in your statement will be put in the record for all posterity to read and to see. They may even cut it in stone somewhere. I don't know where. But they might. Don't bet on it.

Without objection, the hearing record will remain open to receive written testimony from persons who have requested their statement be made a part of this printed record.

Our first witness is Mary Lou Steptoe, who is the Acting Director of the Bureau of Competition for the Federal Trade Commission.

Generally, the subcommittee prefers to hear from Government witnesses separately. In the interest of time, however, Ms. Steptoe has very graciously agreed to appear with the panel.

We appreciate your consideration and we would be delighted to hear from you.

**STATEMENT OF MARY LOU STEPTOE, ACTING DIRECTOR,
BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION**

Ms. STEPTOE. Thank you, sir.

I am here to give my views and the Federal Trade Commission testimony on the relationship between the antitrust law enforcement and health care markets. And I am not really here to discuss any particular legislation. My purpose is to discuss the antitrust exemption theme which seems to be common to many of the legislative proposals.

I would start by pointing out that the Federal Trade Commission's antitrust enforcement over the years has been instrumental in bringing competition to the health care market. We have opened the door to alternatives to traditional fee-for-service health care. And we have stopped conduct that would result in higher prices or reduced quality and choice for consumers of health care services.

It is the Commission's strong belief that continued sound antitrust enforcement will be important to the success of any competition-based model for a future health care market. In other words, whatever piece of legislation you are considering, there is no need for antitrust exemptions.

The Commission does not favor any one type of health care delivery system over another. Rather, it tries to keep markets competitive so that firms may offer and consumers may choose whatever options they prefer.

With this purpose, the Commission as much as 20 years ago challenged the American Medical Association's ethical restrictions which were then preventing doctors from working for a salary paid by an HMO. Our challenge freed up physicians to participate in managed health care plans.

More recently the Commission has stopped a number of boycotts against innovative health care delivery such as a multispecial clinic or nonphysician providers such as nurse-midwives. We have also enjoined a number of conspiracies against cost-containment measures implemented by more traditional health plans and insurance companies. And we have broken up price-fixing cartels.

Finally, we have also preserved competition among institutional providers, that is hospitals, by a merger review program which prevents transactions which will lead to higher prices or reduced service for consumers.

That gives you a flavor of what the Federal Trade Commission's presence has meant to the health care industry and the consumers that it serves. The details are all in the written statement.

I hope when you read the whole chronology in the written statement, you will come away with two key impressions. The first is there is a real need for continuing vigilant antitrust enforcement. There are real problems which have occurred. They are capable of recurring. And they will recur if the cop on the beat is told to take a walk.

And the second impression is the other side of the coin. We have been vigilant but we haven't been heavy handed. Yes, we have stopped boycotts against cost containment, but we have never said providers can't collectively provide information and advocate their views on issues to health care plans. Quite the contrary: Our orders specifically allow this.

And likewise, we made it clear that professional associations can discipline members who do not meet appropriate quality-of-care standards or engage in false, deceptive, and abusive conduct. As to hospital mergers, we have reviewed many hundreds in the last decade and we have challenged exactly 13. We won all but one of the cases we challenged in litigation. We are not standing in the way of procompetitive mergers.

The American Bar Association has said so in a report, and a Health and Human Services task force has said so. That task force specifically focused on the question of rural mergers and concluded that antitrust enforcement was not inhibiting mergers between small rural hospitals. The same thing is true for hospital joint ventures.

The record simply does not suggest that antitrust has disadvantaged consumers of health care services. Rather, it shows that the antitrust enforcement agencies have intervened selectively and precisely in instances where competition has been frustrated and the result is that consumers are faced with higher prices or undue limitations on their health care options.

Now what is really likely to subject consumers to higher prices and reduced choice is not antitrust enforcement; it is the proposed legislative exemptions. Let me give you just one example, spelled out in greater detail in the testimony.

H.R. 3486 immunizes all joint activity by health care providers who comprise less than 25 percent of the total number of, quote, "the same type of providers in the relevant market," end quote. What that means in plain English is that boycotts and price-fixing cartels are legal if they are done by "only" a quarter of the doctors in the market. And if you think that doesn't happen or doesn't happen successfully when it is only a quarter of the doctors in the market, let me tell you about one of our recent cases, and the testimony of the Commission gives further examples.

This is, allegedly, the Southbank matter. Here we had a couple dozen Ob/Gyn's who not once, but twice, forced an HMO to raise reimbursement rates and also, of course, to raise their premiums, passing on to their subscribers the higher costs of health care. Now, these doctors did not represent anywhere near 25 percent of all the Ob/Gyn's in the relevant market, which was Jacksonville, FL. But they did represent most of the obstetricians practicing at the hospital with which that HMO had contracted.

So the HMO was vulnerable. Its choices were to knuckle under to the boycott threat or move its entire subscriber base elsewhere, which is a costly, disruptive, time-consuming process.

And it can get worse. We have one ongoing investigation right now where the Southbank scenario appears to be repeated with a vengeance. Here we are dealing with emergency care specialists, again representing less than 25 percent of their specialty in the relevant market.

What they did, we believe, is shut down an emergency care facility when their demands for higher reimbursement for higher pay weren't met. And this time, of course, the community paid not in mere dollars, which normally I tend to think are pretty valuable—and I think you do too—but here you are talking about patients in the most extreme need of medical care who had to be shipped elsewhere, long distance, at a time when every minute counts and is critical.

I could go on but I would rather end on a positive note, which is that much of what goes on in the health care industry does not pose any antitrust concern. The Federal Trade Commission and the Department of Justice are engaged in an ongoing dialog and a variety of outreach programs—Senator Metzenbaum referred to some of those—in an effort to inform industry participants of just what they can do without incurring antitrust risk.

It is my belief this dynamic, ongoing process, coupled, however, with continued sound antitrust enforcement, is what will best strengthen any models for a health care market.

Thank you very much, sir.

[The prepared statement of Ms. Steptoe follows:]

PREPARED STATEMENT
OF
FEDERAL TRADE COMMISSION

PRESENTED BY
MARY LOU STEPTOE
ACTING DIRECTOR
BUREAU OF COMPETITION
FEDERAL TRADE COMMISSION

BEFORE THE
COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW
UNITED STATES HOUSE OF REPRESENTATIVES

CONCERNING ANTITRUST LAW ENFORCEMENT
AND HEALTH CARE MARKETS

June 15, 1994

Mr. Chairman and members of the Committee: I am Mary Lou Steptoe, Acting Director of the Federal Trade Commission's Bureau of Competition. I am pleased to appear before you today to present the testimony of the Federal Trade Commission on the relationship between antitrust law enforcement and health care markets.¹

There is intense public interest in the various health care proposals that currently are being considered by Congress. The purpose of this testimony is not to comment on any particular proposal;² but representing an agency that for years has been an advocate and defender of the role of competition in health care

1 This written statement represents the views of the Federal Trade Commission. My oral presentation and response to questions are my own, and do not necessarily represent the views of the Commission or any individual Commissioner.

2 The Commission has, however, submitted comments strongly opposing S. 1658 and H.R. 3468, the "Health Care Antitrust Improvements Act of 1993." Those comments were contained in the Commission's June 10, 1994 letters to Chairman Brooks of this Committee and to Chairman Metzenbaum of the Senate Judiciary Committee's Subcommittee on Antitrust, Monopolies and Business Rights, Commissioner Owen dissenting, copies of which are attached to this testimony.

to discuss an element that has figured prominently in the discussions to date -- how the development of managed care and other alternative health care delivery plans relies on competition. The Commission plays a role in protecting competition in the health care sector of the economy through enforcement of the antitrust laws.

There are two principal points. First, antitrust enforcement by the Commission has been instrumental in enabling alternatives to traditional fee-for-service health care arrangements to enter health care markets in the face of opposition by some health care providers. Commission enforcement actions have challenged anticompetitive rules that prohibited physician affiliation with health care plans, and have halted organized boycotts by some health care providers against newly developing health care arrangements.

Second, continued sound antitrust enforcement seems likely to be important to the success of any competition-based model for health care markets. Proposals for broad statutory antitrust exemptions that are now being advocated by some provider groups could frustrate the drive to contain rising health care costs. Experience from the Commission's health care enforcement program suggests that antitrust enforcement plays an important role in preventing organized efforts to reduce price competition and to thwart cost containment efforts.

The antitrust laws have been described by the United States Supreme Court as the "Magna Carta of our free enterprise system." These laws reflect a judgment that competition generally promotes consumer welfare and produces the best mix of quality goods and services at the lowest prices. The antitrust laws also assure business people an opportunity to offer their goods and services in the marketplace, and to have their success or failure determined by consumers' preferences, not by the abuse of market power of other competitors.

The FTC enforces the antitrust laws to ensure that competitive forces will allow the development of health care delivery desired by consumers. The Commission does not favor one type of health care delivery system over another. The agency does not advocate that consumers choose a managed care plan over a fee-for-service health care plan. Nor does the Commission take a position on which kind of health care plan provides better quality health care at lower prices. Instead, the agency tries to ensure that each plan may develop and grow as it meets the wants and needs of consumers. The Commission seeks to ensure that anticompetitive behavior does not impede the development of health care alternatives that consumers might elect to use.

Through sound antitrust enforcement, the FTC has helped allow market forces to create an environment in which innovative forms of health care delivery could emerge to compete on the merits. In that competitive environment, these alternative

health care delivery systems grew as consumers were attracted by the services or lower prices these plans offered. The concepts that form the foundation for some of today's reform proposals were greatly facilitated by antitrust law enforcement.

Before developing these points in greater detail, however, a general caveat is appropriate. Although the Commission firmly believes that antitrust enforcement has been and will continue to be an important factor in allowing for the development of a more cost-effective health care delivery system, antitrust cannot, and will not, alone solve the problem of controlling health care costs. The suggestion is a more modest one: that antitrust has a role to play in fostering competition in health care markets and thereby facilitating other cost containment efforts. The Federal Trade Commission can and should continue to play a significant, constructive role in this process.

I. The Contribution of Antitrust Enforcement to the Development of Health Care Plans

Understanding the role that antitrust enforcement has played during the last two decades in opening health care markets to new forms of competition requires an historical perspective. Until the late 1970's, most physicians practiced solo, fee-for-service medicine. There were few alternative arrangements. Even multi-specialty group practices were rare, and health care plans that sought to compete by signing up a limited panel of selected physicians were impeded by a variety of restrictions. Most hospitals operated in a similarly independent fashion.

The early forerunners of today's managed care arrangements met with opposition. Some physicians who associated with such plans were the targets of reprisal, facing charges of unethical conduct, expulsion from local medical societies, and loss of hospital privileges. In 1943, the Supreme Court upheld a criminal antitrust conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association, an early health maintenance organization ("HMO").³ The associations had taken disciplinary actions against Group Health staff physicians, imposed sanctions against doctors who consulted with Group Health physicians, and threatened disciplinary action against hospitals at which Group Health doctors were permitted to practice.

Notwithstanding the Supreme Court's decision, alternative health delivery systems, and physicians who associated with them, continued to face opposition to their activities. In 1975, the

³ American Medical Ass'n v. United States, 317 U.S. 519 (1943).

Commission issued an administrative complaint challenging the AMA's ethical standards. The complaint alleged that the AMA's ethical restrictions prohibited physicians from providing services to patients under a salaried contract with a "lay" hospital or HMO, "underbidding" for a contract or agreeing to accept compensation that was "inadequate" compared to the "usual" fees in the community, and entering into arrangements whereby patients were supposedly denied a "reasonable" degree of choice among physicians. In 1979, the Commission held that all of these restraints violated the antitrust laws.⁴

Even after the Commission's AMA case freed physicians to affiliate with health care plans, non-traditional health care plans often continued to face boycotts by providers. While some providers join managed care plans, and many others compete against them on the merits, experience shows that some providers have engaged in illegal concerted action to resist new forms of competition. The Commission has taken action to remedy alleged conduct such as obstructing hospital privileges for HMO physicians⁵ and boycotting a hospital that was planning to open an HMO facility.⁶

Within just the last few years, the Commission has issued a series of orders against alleged threatened boycotts by physicians to prevent local hospitals from pursuing affiliation with the Cleveland Clinic, a nationally known provider of

4 American Medical Ass'n, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd per curiam by an equally divided Court, 455 U.S. 676 (1982). HMOs and other managed care plans attempt to achieve cost-effectiveness by limiting the provider panel to those known to provide the desired quality of care, giving this limited panel incentives to control costs, and in some instances exercising direct supervision over the appropriateness of the course of treatment selected. While patient choice of providers is limited once the patient has enrolled in such a plan, the existence of these plans allows the purchasers to decide whether the cost savings the plans offer are worth accepting this limitation. But prohibitions of "inadequate" fees or requirements of "reasonable" provider choice can impede the ability of these plans to compete effectively.

5 Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order).

6 Medical Staff of Doctors' Hospital of Prince Georges County, 110 F.T.C. 476 (1988) (consent order).

comprehensive health care services.⁷ The Clinic, which operates as a multi-specialty group medical practice, offers a predetermined "global fee" or "unit price" covering all aspects of many services, such as surgery. The Commission's complaints alleged that when the Clinic sought to establish a facility in Florida, local physicians sought to prevent its physicians from gaining hospital privileges by threatening to boycott the hospitals. The Commission's orders prevent such activity from recurring.

In addition to challenging conspiracies against HMOs and other innovative arrangements for health care delivery, the Commission has enjoined a number of conspiracies to obstruct cost containment measures being implemented by more traditional health plans, such as Blue Shield plans and insurance companies. For example, in the 1970's, Blue Shield of Michigan introduced several proposals to contain the rising cost of physicians' services. The state medical society responded by forming a "negotiating committee" that orchestrated boycotts of the plan to defeat cost containment. In Michigan State Medical Society, the Commission prohibited such joint "negotiations."⁸ In FTC v. Indiana Federation of Dentists,⁹ the Supreme Court unanimously affirmed a Commission decision halting a conspiracy among dentists to frustrate a cost containment program by withholding dental X-rays from insurers. The refusal to provide the X-rays frustrated the cost containment effort by preventing the efficient operation of utilization control mechanisms.¹⁰ The Commission also has obtained a consent order that required the dissolution of an allegedly "sham" venture among physicians who were not economically integrated but simply operated to conduct joint negotiations to defeat the cost reduction initiatives of third-party payors.¹¹

Most recently, the Commission entered a consent order settling charges that an Illinois association of chiropractors had engaged in a price-fixing conspiracy and attempted to negotiate fees and other terms with third-party payors on behalf

7 Diran Seropian, M.D., Dkt. No. 9248, 57 Fed. Reg. 44748 (1992) (consent order); Medical Staff of Holy Cross Hospital, C-3345, 56 Fed. Reg. 49184 (1991) (consent order); Medical Staff of Broward General Medical Center, C-3344, 56 Fed. Reg. 49184 (1991) (consent order).

8 101 F.T.C. 191, 296, 313-14 (1983).

9 476 U.S. 447 (1986).

10 Id. at 461.

11 Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913 (1992).

of its members.¹² The Commission also has recently entered several consent orders with associations of pharmacies and their members that had allegedly organized boycotts to thwart third-party-payor attempts at cost containment, by jointly threatening to withdraw as providers from the payors' prescription drug benefit programs unless the pharmacies' compensation demands were met.¹³

Commission enforcement in pharmaceutical markets has not been confined to pharmacy boycotts. The Commission issued an order preventing Sandoz Pharmaceutical Corporation from "tying" its antipsychotic drug, clozapine, to a blood testing and monitoring service.¹⁴ This action likely saved the Department of Veterans Affairs, one major purchaser of clozapine, \$20 million a year.¹⁵

Not long ago, two leading manufacturers of infant formula settled Commission charges that they had engaged in unilateral facilitating practices (signalling competitors) to eliminate competitive sole-source bidding in the federal government's Women, Infants, and Children (WIC) program in Puerto Rico. The manufacturers agreed to refrain from such actions in the future and to provide restitution in the form of 3.6 million pounds of free infant formula to the U.S. Department of Agriculture, which administers the WIC program.¹⁶

12 McLean County Chiropractic Ass'n., C-3491, 59 Fed. Reg. 22163 (Apr. 29, 1994) (consent order).

13 Baltimore Metropolitan Pharmaceutical Ass'n, Inc., D. 9262, 59 Fed. Reg. 15733 (Apr. 4, 1994) (consent order). See also, Southeast Colorado Pharmacal Ass'n, C-3410, 58 Fed. Reg. 6796 (1993) (consent order); Peterson Drug Company, No. D-9227 (1992) (Commission adopted opinion of Administrative Law Judge after appeal withdrawn); Chain Pharmacy Ass'n, No. D-9227, 56 Fed. Reg. 9223 (1991); Pharmaceutical Soc'y of Orange County, Inc., 113 F.T.C. 645 (1990) (consent orders).

14 Sandoz Pharmaceutical Corp., C-3385, 57 Fed. Reg. 36403 (1992) (consent order).

15 In a second health care tying case, the Commission prohibited the owner of certain renal dialysis clinics from using a tying arrangement to circumvent Medicare reimbursement limits on outpatient dialysis services. Gerald S. Friedman, M.D., 113 F.T.C. 625 (1990) (consent order).

16 FTC v. Mead Johnson & Co., No. 92-1366 (D.D.C. June 11, 1992) (consent order); FTC v. American Home Products Corp., No. 92-1365 (D.D.C. June 11, 1992) (consent order).

The antitrust enforcement actions just described by no means exhaust the categories of the Commission's efforts to preserve competition and thus permit the market to expand the number and variety of available health care plans. For example, the Commission has brought cases that challenged restrictions on the delivery of health care services by non-physician providers, such as nurse-midwives or podiatrists.¹⁷ The Commission does not side with non-physicians against physicians, or vice versa, but seeks to ensure that consumers have the opportunity to choose between them. In general, antitrust enforcement seeks to ensure that physicians and non-physician professionals are able -- so far as possible -- to compete on a level playing field. The resulting expanded range of choice benefits both health care plans and individual health care consumers.

Also important to health care cost containment is the preservation of competition among institutional providers of health care services, including hospitals. Thus, the Commission's review of hospital mergers helps to maintain competitive conditions that enable consumers and health care plans to choose among competing alternatives. To enable the continuation of competitive choice, the Commission has also brought non-hospital merger cases in the health care area. In the last few years the Commission has entered into consent orders restructuring transactions among firms producing such diverse health care products as dental amalgams, human growth hormone, and wheelchair lifts.¹⁸ By preventing transactions that are likely to reduce competition and lead to higher prices in a broad spectrum of health care markets, the Commission's merger enforcement contributes to the overall health care cost containment effort.

II. Antitrust Exemptions and Health Care Reform

Just as sound antitrust enforcement has contributed significantly to the growth of alternative arrangements in the health care sector, so it is likely to be an important underpinning of future reform. The Commission's experience in health care markets has shown that, without the protection that antitrust law provides, efforts to contain health care costs

17 For example, the Commission prohibited boycotts of nurse midwives (State Volunteer Mutual Ins. Co., 102 F.T.C. 1232 (1983) (consent order)) and podiatrists (North Carolina Orthopaedic Ass'n, 108 F.T.C. 116 (1986) (consent order)).

18 Dentsply International, Inc., C-3407, 58 Fed. Reg. 6796 (1993) (consent order); American Stair-Glide Corp., C-3331, 56 Fed. Reg. 26108 (1991) (consent order); Roche Holding Ltd., 113 F.T.C. 1086 (1990) (consent order).

sometimes can be frustrated by the opposition of certain providers.

Nonetheless, there have recently been a variety of proposals to create special antitrust exemptions for collective action by hospitals and physicians. Some seek an exemption for mergers and various kinds of joint ventures. Others seek an exemption for various forms of concerted action -- in particular, collective negotiations with health care purchasers and payors. Without getting into the specifics of any proposal, an explanation of the reasons for concern about exemptions in this area might prove useful.¹⁹

At their core, the proposed exemptions for physicians and hospitals may be based on questionable arguments about the nature of competition in health care markets and how antitrust law applies to physicians and hospitals. One argument is that due to market imperfections, competition in health care does not work to contain costs and ensure quality. The other argument is that antitrust law is not flexible enough to deal with markets, such as many health care markets, that may not resemble perfect competition. However, the record of antitrust enforcement in the health care field shows that competition is important to containing costs and ensuring quality, and that antitrust enforcement is flexible enough to prevent harmful conduct without interfering with efficient joint conduct that benefits consumers.

The Commission has not simply dismissed the concerns of those who are calling for antitrust exemptions. Through discussions with some of these groups, and with others, it has become apparent that much of the impetus for antitrust exemptions is due to health care providers' uncertainty about whether various collaborative activities that they may wish to undertake expose the providers to the possibility of being subject to antitrust law enforcement proceedings. This is a legitimate concern, and the FTC and the Department of Justice already have made substantial efforts to address it.

One of the most important responses to the concerns of health care providers has been the joint issuance, last September, of Statements of Antitrust Enforcement Policy in the Health Care Area. These Statements underscore the commitment of the Federal Trade Commission and the Department of Justice to clarify the agencies' enforcement intentions as to collaborative activities among health care providers. The policy statements are designed to resolve uncertainties that some have said may

19 As noted above, specific comments on the proposed antitrust exemptions in S. 1658 and H.R. 3468, the "Health Care Antitrust Improvements Act of 1993," are contained in the Commission's June 10, 1994 letters to Chairman Brooks and Chairman Metzenbaum.

inhibit collaborative ventures that would lower health care costs. Much of the enforcement guidance contained in the policy statements is drawn from prior advice rendered by the agencies in a variety of forms. The statements bring together this advice, as well as some new advice, in a format that is easily accessible both to attorneys and to health care providers.

The policy statements define six "antitrust safety zones" -- relating to activities by hospitals and physicians -- within which conduct will not be challenged by the enforcement agencies, absent extraordinary circumstances. The safety zones cover small hospital mergers; hospital joint ventures involving high-technology or other expensive medical equipment; hospital participation in exchanges of price and cost information; physicians' provision of certain kinds of information to purchasers of health care services; joint purchasing arrangements among health care providers; and physician network joint ventures, such as IPAs and PPOs.

The antitrust safety zones serve to clarify what health care providers can do together in certain areas, with little or no antitrust risk. The safety zones do not define the outer limits of lawful collaboration in these areas. Each of the six policy statements sets forth the analysis that the federal enforcement agencies will use in evaluating conduct that falls outside the safety zone.

For those matters that are not specifically addressed in the policy statements, the Commission invites health care providers to seek its advice. The Commission has committed to respond to requests for advice on matters addressed within the policy statements (except hospital mergers outside the safety zone) within 90 days after all necessary information is received. Likewise, it has committed to respond to requests for advice on all other non-merger health care matters within 120 days of receipt of all necessary information.

One of the Bureau of Competition's most recent health care staff opinion letters was issued last November to a physician joint venture, California Managed Imaging Medical Group, Inc. ("CMI"), a radiology preferred provider group.²⁰ CMI proposed to establish a network of radiologists to provide diagnostic imaging review and interpretation services to third-party payors, in competition with existing broker networks.

The staff opinion letter approved operation of the proposed network based on several considerations. First, the staff concluded that CMI was a legitimate joint venture that was

20 Letter to J. Bert Morgan from Mark J. Horoschak, Assistant Director, Bureau of Competition (November 17, 1993).

potentially procompetitive. Under the rule of reason, operation of CMI did not appear likely to restrict competition, because it did not appear likely that CMI would attain market power. In addition, its contracts with participating radiologists were nonexclusive. For these reasons, it did not appear that operation of CMI was likely to have the power either to foreclose entry by competing radiology networks, or to force payors to deal with CMI or its participating radiologists on terms dictated by them.

The CMI staff opinion letter is just one of many health care antitrust options offered to providers by the Commission and the Commission staff. In order to help providers to learn about prior advisory opinions that may address their concerns, the Bureau of Competition last week published a summary and index of all Commission and staff health care advisory opinions issued to date. Finally, of course, the Commission's staff is always willing to provide less formal advice on proposed conduct. At this time the Commission's staff is working with several providers to help them develop procompetitive arrangements that bear minimal antitrust risks.

Furthermore, FTC and Department of Justice staff have met recently with representatives of various provider groups to attempt to address remaining issues. This multi-faceted approach to reducing health care providers' uncertainty about antitrust risks through policy statements, safety zones, and formal and informal advisory opinions is an ongoing and dynamic process. The Commission believes that these efforts will go a long way toward allaying providers' concerns.

A. Hospital Exemptions

Recently, Congress has considered a number of proposals for special antitrust exemptions for hospital mergers and joint ventures. Certain groups have proposed legislation that would allow hospitals, under some circumstances, to obtain antitrust immunity for combining their operations, or sharing medical services or equipment.

Is there a need for this type of legislation? The proponents offer two arguments. First, they contend that due to widely perceived uncertainty about the antitrust laws' prohibitions, efficient mergers and joint ventures among hospitals are prevented or inhibited. Second, and more broadly, they contend that there is an inherent conflict between the antitrust laws and demands to contain costs by eliminating unnecessary duplication of services and facilities. The available evidence fails to support their assertions.

Sound antitrust enforcement does not hinder efficient, procompetitive collaborations. This issue needs consideration in

perspective. In a typical year, there are about 50 to 100 hospital mergers or other arrangements consolidating previously independent hospitals. Review of these transactions by Commission staff normally entails minimal or no direct contact with the parties and no delay in the transaction beyond statutory Hart-Scott-Rodino requirements. In the past decade, the Commission has conducted only about thirty formal investigations, mostly involving larger metropolitan hospitals, and has challenged only 13 hospital mergers.

An illustration of this principle can be made by just one example. In the last year, Columbia Hospital Corporation, through successive mergers with Galen Health Care, Inc., and HCA-Hospital Corporation of America, grew from a system of about 20 hospitals to one involving more than 160 acute care hospitals in 26 states. The staff looked at the competitive impact of those mergers in every geographic area where the mergers involved an overlap in hospital ownership by the merging parties. The Commission charged that the mergers raised substantial competitive concerns warranting divestiture of a hospital in only two geographic areas. Columbia agreed, by consent order, to divest the two hospitals at issue in those markets.²¹ The consolidation under common ownership of the approximately 160 other hospitals was permitted to proceed without antitrust interference.

The Commission's assessment of the impact of antitrust enforcement on hospital collaborations has been confirmed both by a substantial increase in such activity recently -- which suggests that fear of antitrust enforcement has not dampened hospital mergers generally -- and by other observers. Recently, a Health Care Task Force of the American Bar Association concluded that, "Overall antitrust enforcement has not deterred hospital mergers and in fact, the hospital industry has seen a recent wave of mergers."²² Similarly, a Department of Health and Human Services task force examined the claim that enforcement agencies have become too adversarial in challenging hospital

21 Columbia Hospital Corporation/Galen Health Care, Inc., No. C-3472, 58 Fed. Reg. 65721 (1993) (consent order); Columbia Healthcare Corporation/HCA-Hospital Corporation of America, No. 941-0005, 59 Fed. Reg. 10389 (March 4, 1994) (consent order accepted for public comment). The Commission also recently issued a consent order blocking Columbia's acquisition of a single hospital in Punta Gorda, Florida. Columbia Hospital Corp., Dkt. No. 9256 (consent order issued May 5, 1994).

22 American Bar Association Working Group on Health Care Reform, "Antitrust Implications of Health Care Reform" (May 14, 1993) at 4.

mergers, concluding that the assertion was not supported by the evidence.²³

The enforcement record on hospital joint ventures similarly should not evoke concern. To date, the Commission has not challenged a single joint venture among hospitals. Indeed, in the context of merger enforcement, the Commission has expressly allowed various types of hospital joint ventures that are not likely to raise serious antitrust concerns. In a recent order blocking a hospital merger in a highly concentrated market, the Commission exempted from the order's reporting requirements any prospective joint ventures the hospitals might decide to undertake to provide data processing, laboratory testing, and health care financing.²⁴ These joint ventures appeared likely to achieve efficiencies and improve specific services, without endangering price and quality competition for other competitive services, as a complete merger could.

23 Report of the Secretary's Task Force on Hospital Mergers, at 11 (Jan. 1993). The report noted that between 1987 and 1991 the FTC and the Justice Department investigated only 27 of 229 hospital mergers and challenged only 5 transactions. The HHS task force specifically addressed the issue of rural hospital mergers, which has been the subject of some attention of late. It found that there was no evidence that the possibility of scrutiny by the antitrust enforcement agencies adversely affected consolidation among hospitals in rural markets. The task force also found that very few such mergers are investigated, and concluded that there was "no need to exempt and therefore tacitly encourage mergers among hospitals in rural or 'small' urban settings." Id. The task force report supports the Commission's contention that antitrust enforcement does not inhibit efficient mergers in the hospital area. For example, hospital merger and joint venture activity has been so vigorous that an article in Modern Healthcare was entitled "Mergers Thrive Despite Wailing About Adversity." After an examination of the record, the article dismissed the claim that antitrust enforcement inhibited hospital consolidation. Modern Healthcare, Oct. 12, 1992, at 30.

24 University Health, Inc., FTC Dkt No. 9246, 57 Fed. Reg. 44748 (1992) (consent order) (exempting a wide range of support service joint ventures). See Federal Trade Commission v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991) (upholding FTC challenge to acquisition of hospital). See also The Reading Hospital, 113 F.T.C. 285 (1990) (consent order) (the Commission determined that voluntary separation of the merged hospitals was sufficient to restore them as independent competitors, even though both hospitals continued to participate in hospital-sponsored health plan joint ventures, and to share laundry, laboratory, and biomedical equipment repair services).

The great majority of hospital mergers and joint ventures -- like those in most lines of business -- do not endanger competition. Most hospital mergers do not pose a threat to competition because they occur in markets with a substantial number of competitors. Indeed, many hospital mergers may enhance efficiency and promote competition. Similarly, many hospital joint ventures are efficiency-enhancing. Joint ventures can make new technologies available to communities that otherwise could not have them and can spread the cost of ownership of expensive equipment among competing providers. But joint ventures need not be confined to the acquisition of expensive technologies. They may also facilitate the provision of essential services to a community. Thus, it may not be surprising that most hospitals engage in some forms of joint venture activity. To cite but one example, virtually all hospitals acquire many of their day-to-day supplies through buying cooperatives.²⁵

But the fact that most hospital mergers and joint ventures are procompetitive (or, at worst, competitively neutral) does not mean that there is no place for antitrust enforcement in hospital markets. Some transactions involving hospitals are anticompetitive, and the Commission seeks to ensure that health care consumers have a sufficient selection of competing providers to be able to shop for the best possible bargain.

In hospital merger investigations, the Commission examines a broad range of evidence concerning the likely impact of the merger on health care costs. Market concentration figures standing alone do not determine whether the Commission will seek an enforcement action. One of several factors to be examined is the views of buyers of hospital services including insurance companies, health care plans, and large employers. In many of these investigations, these buyers have stated that competition among hospitals is important because it permits them to get better deals. When the Commission reviews hospital mergers, it considers whether the merger will help or hurt payors and health care plans in their attempts to hold down cost increases. If hospital mergers are exempted from the antitrust laws, hospitals may be able to acquire market power and resist such cost-containment efforts.

Finally, the argument that merger enforcement in the health care area actually leads to higher, not lower, health care costs deserves a response. The argument heard with increasing frequency is that competition among hospitals should not be encouraged because it leads to costly duplication of services and facilities. This argument was made to the Commission in defense of a proposed merger a few years ago. The Commission found that

25 See Nearly All Hospitals Use Group Purchasing, Modern Healthcare (Dec. 24-31, 1990), at 40.

the argument was contradicted by a great deal of evidence in that case, including internal hospital documents stating that "increasing competition in the health care sector . . . will allow natural market forces to slow the price spiral."²⁶

The Commission's experience in merger enforcement in the health care area has demonstrated that mergers can result in the elimination of duplicative services. Depending on the specific market conditions, this can be pro-competitive or anticompetitive. In some circumstances, elimination of redundant underutilized facilities can improve the effectiveness of operating those that remain. In other circumstances, however, where demand supports the existing level of supply of services, care must be taken to ensure that eliminating duplication does not become simply an excuse for avoiding competition.

B. Exemptions for Professionals

Current proposals for an antitrust exemption for physicians focus on physicians' dealings with purchasers and payors of health care services. Today many physicians compete to be selected by one or more health care plans. Through this competition among physicians, plans seek to employ enough quality physicians without paying unnecessarily high prices. One exemption supported by certain health care professionals would permit competing physicians to eliminate competition by joining together and, without engaging in any risk sharing or integration of their practices or finances, collectively bargaining with large purchasers and payors of health care services.

Purchasers and payors that represent a large number of consumers may have sufficient clout and knowledge to bargain aggressively with physicians and other health care providers to obtain lower charges and adherence to a variety of cost-containment measures. An exemption allowing sellers of health care services to aggregate for bargaining purposes may, however, enable providers to defeat legitimate cost containment efforts that benefit consumers.

The argument for exempting health care providers' joint bargaining from antitrust scrutiny is based on the questionable premise that health care purchasers possess market power and can therefore artificially depress health care prices. In most markets, however, there appear to be a large number of medical care alternatives, including Blue Cross and Blue Shield plans, numerous commercial insurers, HMOs, and other firms that offer health insurance or benefits. In the absence of market power on

²⁶ Hospital Corp. of America, 106 F.T.C. 361, 478-87 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).

the part of large purchasers and payors, permitting physicians to aggregate their power would not create a "counterbalance," but rather could give physicians unconstrained market power and the ability to raise prices for health care services. Even in circumstances in which the number of payors is limited, the Commission is not aware of any evidence to suggest that allowing physicians to collaborate in negotiating prices will lead to any benefits to consumers.

One need not rely on theories to see what happens when provider groups collectively "negotiate" with payors and purchasers. A good example is the Michigan State Medical Society case. To satisfy consumers, the plan needed to have contracts with a large enough number of physicians who would agree to accept the plan's payment as payment in full. The plan relied on competition among physicians to obtain the right number and mix of physicians, but physicians agreed among themselves that they would not compete over the terms they would accept from Blue Shield. Instead, these physicians agreed that none of them would join the plan unless and until the plan responded to the demands of the medical society. This agreement resulted in higher quality-adjusted prices.

No antitrust exemption is necessary for physicians to serve, individually and collectively, as forceful advocates for their patients and profession; that is clearly legal under the antitrust laws. But as the Commission and court decisions make clear, the collective judgment of health care providers concerning what patients should want can differ markedly from what patients themselves are asking for already in the marketplace. The point is straightforward. Physicians can engage in forceful advocacy and provide information to health plans without an antitrust exemption.²⁷ The Commission has made clear in its remedial orders governing physician boycotts that physicians may nonetheless jointly provide information to payors (or insurers).²⁸ But an antitrust exemption for "collective negotiations" could permit providers to override consumer choice and harm our economy.

Lately certain health care providers have claimed that antitrust enforcement interferes with responsible self-regulation

27 The Commission's Analysis of Proposed Consent Order to Aid Public Comment in the Chain Pharmacy Association matter illustrates this distinction. Chain Pharmacy Ass'n of New York State, Inc., Dkt. No. 9227, 56 Fed. Reg. 12534, 12541 (1991).

28 See e.g., Southbank IPA, Inc., C-3355, 57 Fed. Reg. 2913 (1992) (consent order); Rochester Anesthesiologists, 110 F.T.C. 175, 180-81 (1988) (consent order); Michigan State Medical Society, 101 F.T.C. 191, 307-08, 314 (1983).

by groups of health care providers, and that antitrust prevents such groups from addressing problems of fraud and abuse. Be assured that this simply is not the case. Antitrust law does not prevent professional associations from disciplining or expelling members who do not meet appropriate quality of care standards, or who engage in false, deceptive, or other abusive behavior. Many Commission orders involving health care professionals contain provisions explicitly permitting the regulation of false and deceptive dissemination of information.²⁹ As the Commission emphasized in its 1979 opinion in the AMA case, professional associations "have a valuable and unique role to play" regarding deceptive and oppressive conduct by their members.³⁰ Such programs can provide valuable information to patients and others who pay for medical care, and, as long as they are properly structured, present no antitrust concerns.

The ability of antitrust law to accommodate professional self-regulation that benefits consumers also is illustrated by a Commission advisory opinion recently issued to the American Medical Association and the Chicago Medical Society.³¹ These organizations requested the Commission's opinion on the legality of the proposed system of medical society peer review of physicians' fees that AMA intends to urge its state and local societies to implement. More than a decade ago, in an advisory opinion issued to the Iowa Dental Association,³² the Commission approved the proposed operation of a fee review system that was voluntary for all parties, advisory, and confidential. The system proposed by AMA and CMS is similar in many respects to that considered in Iowa Dental, but has three significant differences: (1) members of medical societies would be required to participate in peer review proceedings; (2) physicians would be subject to discipline for certain fee practices; (3) and the fact of a disciplinary action against a physician would be made public.

The Commission approved the operation of most, though not all, of the proposed fee review system. The Commission's opinion reaffirms the principle that, with appropriate safeguards, advisory fee review is likely to promote competition by giving

29 See American Psychological Ass'n, C-3406, 58 Fed. Reg. 557 (1993); National Ass'n of Social Workers, C-3416, 57 Fed. Reg. 61424 (1992).

30 American Medical Ass'n, 94 F.T.C. at 1029.

31 Letter from Donald S. Clark, FTC Secretary to Kirk B. Johnson, General Counsel, American Medical Association, and John M. Peterson (February 14, 1994).

32 99 F.T.C. 648 (1982).

patients and insurers information about the basis for a fee and an informed opinion about its reasonableness. The opinion goes on to state that requiring physicians to participate in advisory peer review proceedings as a condition of medical society membership is reasonably related to making information available to consumers, and is not likely to endanger competition. The opinion further states that imposing discipline where the fee review reveals that a physician has engaged in fraud, deception, or other abusive practices would not jeopardize competition. Making legitimate disciplinary actions public likewise would not endanger competition.

At the same time, the Commission reaffirmed the basic antitrust principle that a group of competitors may not regulate the fees charged by its members. Accordingly, the Commission did not approve the disciplinary program to the extent that it contemplated authorizing medical societies to discipline members on the basis of fee levels alone, without regard to the presence of abusive conduct. Such a program, the Commission concluded, would pose a substantial likelihood of injury to consumers. The Commission emphasized, however, that AMA and CMS could take other steps -- such as requiring physicians to disclose to patients in advance certain information about price -- in order to address the problem of information disparities in markets for medical services.

Conclusion

The Commission wants to reiterate the two principal points of today's testimony. First, antitrust enforcement by the Commission has been instrumental in enabling alternatives to traditional fee-for-service health care arrangements to enter health care markets in the face of opposition by some health care providers. Second, continued sound antitrust enforcement seems likely to be important to the success of any competition-based model for health care markets.

Thank you for the opportunity to present this testimony. I would be happy to answer your questions.



Office of
the Chairman

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON D.C. 20580

June 10, 1994

The Honorable Jack Brooks
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Brooks:

The Federal Trade Commission is pleased to respond to the recent letter, from you and Chairman Howard M. Metzenbaum of the Senate Subcommittee on Antitrust, Monopolies and Business Rights, requesting the views of the Commission on S. 1658 and its virtually identical companion bill, H.R. 3486, the "Health Care Antitrust Improvements Act of 1993," introduced, respectively, by Senators Hatch and Thurmond, and Representative Archer. The Federal Trade Commission concurs with Assistant Attorney General Bingaman's views as discussed in her letters of April 14, 1994, to you and Chairman Metzenbaum that the proposed special interest exemptions from the antitrust laws and the creation of an unnecessary regulatory scheme without countervailing benefits would harm consumers. For the reasons discussed below, the Federal Trade Commission, like the Department of Justice, strongly opposes enactment of S. 1658 and H.R. 3486.¹

¹ This letter discusses certain aspects of the proposed legislation that we believe are particularly troublesome. However, the absence of comment on other aspects or provisions of the bills should not be interpreted as indicating that those aspects or provisions are unobjectionable. The Commission has restricted its comments at this time to the broader substantive implications of the bills, omitting such concerns as ambiguities in, or unresolved issues raised by, specific provisions. However, the Commission notes that the bills do contain ambiguities or unresolved issues. Thus, for example, while three of the seven proposed safe harbors are not discussed specifically in the letter, the Commission nevertheless believes that these too are inadvisable, since they are unnecessary, substantively expand the related safety zones in the joint FTC/DOJ Statements, and do not permit flexibility in their application to deal with unforeseen, extraordinary, or changed circumstances. In addition, many points already have been made clearly and forcefully in Assistant Attorney General Bingaman's letter to you, and accordingly need not be repeated here.

(Continued...)

Overview and Background

The antitrust laws have been described by the United States Supreme Court as the "Magna Carta of our free enterprise system." The laws reflect a judgment that competition generally promotes consumer welfare and produces the best mix of quality goods and services at the lowest prices. The antitrust laws also assure business people an opportunity to offer their goods and services in the marketplace, and to have their success or failure determined by consumers' preferences, not by the abuse of market power of other competitors.

The Federal Trade Commission enforces the antitrust laws to ensure that competitive forces will allow the development of health care delivery systems desired by consumers. The Commission does not favor one type of health care delivery system or one provider group over another. Nor does the Commission take a position on which kind of health care plan provides better quality health care at lower prices. Instead, the Commission seeks to ensure that anticompetitive behavior does not impede the development of health care alternatives that consumers might elect to use.

Through sound antitrust enforcement, the Federal Trade Commission and the Department of Justice have helped allow market forces to create an environment in which innovative forms of health care delivery could emerge to compete on the merits. In that competitive environment, these alternative health care delivery systems grew as consumers were attracted by the services or lower prices these plans offered. Experience from the Commission's health care enforcement program suggests that antitrust enforcement plays an important role in preventing organized efforts to reduce price competition and to thwart cost containment efforts. Obstacles to the development of the service delivery mechanisms that form the foundation for some of today's health care reform proposals were eliminated by antitrust law enforcement. Continued sound antitrust enforcement seems likely to be important to the success of any competition based model for health care markets.

¹(...continued)

In addition, the National Association of Attorneys General ("NAAG") adopted a resolution [attached] at its spring meeting of March 20-22, 1994, "Opposing Preemption of State Antitrust Enforcement in the Health Care Area." In its background statement NAAG pointed out that S. 1658 provides an exemption from state as well as federal antitrust laws for activities by health care providers within certain legislatively established safe harbors.

The proposed exemptions contained in S. 1658 and H.R. 2486, however, if enacted, would insulate from antitrust law enforcement many activities that could reduce or eliminate competition and thereby seriously harm consumers. The bills also unnecessarily create a cumbersome and costly regulatory system for reviewing and certifying joint activities by providers. As Assistant Attorney General Bingaman said in her letter to you, the "antitrust laws have for over a century been the principal guarantor of competition in the American system and have time and again proved far superior to pervasive government review, regulation, and oversight of collective activities that may have competitive consequences." By permitting such anticompetitive activities by health care providers, these exemptions also could interfere with the effective operation of the health care system under any program for reform that relies on competition.

Moreover, there is no need or sound justification for these exemptions. The federal antitrust agencies' record of responsible and judicious antitrust law enforcement makes clear that broad antitrust exemptions are unnecessary for health care providers to participate effectively in procompetitive arrangements in the marketplace. In applying the antitrust laws to the health care area, as in other sectors of the economy, the Commission fully considers increased efficiency, better quality, lower costs, and other benefits to consumers that may result from joint activities by those offering their services in the marketplace.

The federal enforcement agencies have undertaken new initiatives and stepped up existing programs to help alleviate health care providers' uncertainty about the antitrust laws' application to their activities. Considerable information and guidance about the Commission's antitrust law enforcement activities and analysis of joint activities in the health care area is offered to health care providers and others through published opinions of litigated cases, Commission and staff advisory opinions, speeches by Commissioners and staff, and informal advice and communications. In order to help providers learn about prior advisory opinions that may address their concerns, in early May the Commission's Bureau of Competition published a summary and index of Commission and staff health care advisory opinions. In addition, the Commission's staff is always willing to provide informal advice on proposed conduct. At this time the Commission's staff is working with several providers to help them avoid antitrust risks in their development of procompetitive arrangements.

The Commission and the Department of Justice, last September, jointly issued Statements of Antitrust Enforcement Policy in the Health Care Area ("FTC/DOJ Statements" or "Statements"). These Statements underscore the commitment of the Federal Trade Commission and the Department of Justice to

clarifying the agencies' enforcement intentions as to collaborative activities among health care providers. The FTC/DOJ Statements are designed to resolve the perception of uncertainties that some have said may inhibit collaborative ventures in health care. The Statements collect previously published advice, as well as some new advice, in a format that is accessible both to attorneys and to health care providers.

The FTC/DOJ Statements define six "antitrust safety zones" - relating to activities by hospitals and physicians -- within which conduct will not be challenged by the enforcement agencies, absent extraordinary circumstances. The safety zones cover small hospital mergers; hospital joint ventures involving high-technology or other expensive medical equipment; hospital participation in exchanges of price and cost information; physicians' provision of certain kinds of information to purchasers of health care services; joint purchasing arrangements among health care providers; and physician network joint ventures, such as IPAs and PPOs.

The antitrust safety zones serve to clarify what health care providers can do together in certain areas, with little or no antitrust risk. The safety zones describe the minimal levels of lawful conduct with respect to collaborative efforts. The six FTC/DOJ Statements also set forth the analysis that the federal enforcement agencies use in evaluating conduct that falls outside the safety zones. Commission and Department of Justice staff continue to meet with representatives of various provider groups to address remaining issues of concern to providers.

For matters not specifically addressed in the FTC/DOJ Statements, the federal enforcement agencies have invited health care providers to seek their advice. The agencies have committed to respond to requests for advice on matters addressed within the Statements (except hospital mergers outside the safety zone) within 90 days after the necessary information is received and to respond to requests for advice on all other non-merger health care matters within 120 days of receipt of all necessary information.

This multi-faceted approach to reducing health care providers' uncertainty about antitrust risks through policy statements, safety zones, and formal and informal advisory opinions is an ongoing and dynamic process. In the Commission's view, these actions should allay any legitimate concerns and uncertainty about the legality of their joint activities under the antitrust laws.

Finally, the bills establish a notification procedure that would require all conduct for which notification is made or deemed to be made to be evaluated under a rule of reason standard -- even conduct, such as price-fixing, that absent notification

under the statute is evaluated under a per se illegality standard -- and reduce the remedies available, in any private antitrust lawsuit against even the most clearly anticompetitive and potentially harmful conduct undertaken by a "health care cooperative venture." Private antitrust law enforcement is an important complement to the enforcement programs of the federal and state antitrust agencies. The proposed changes in the antitrust standards and remedies under this part of the bills appear likely to discourage private parties and state agencies from bringing meritorious antitrust lawsuits against conduct that harms consumers.

Antitrust Exemptions

Section 2 of S. 1658 and H.R. 3486 broadly exempt from the federal antitrust laws "activity relating to the provision of health care services" (1) that falls within any of the seven "safe harbors" in Section 3 of the bills; (2) that falls within any additional safe harbors designated by the Attorney General pursuant to Section 4 of the bills; or (3) that is covered by a "certificate of review" issued by the Attorney General with the concurrence of the Secretary of Health and Human Services under Section 5 of the bills.

A. Statutory Safe Harbors

While several of the safe harbors included in Section 3 of the bills appear to be patterned, in part, on the safety zones described in the FTC/DOJ Statements, most of the proposed safe harbors are considerably broader than the safety zones in the joint FTC/DOJ Statements. In many instances, such as the safe harbor for joint conduct by providers, the bills would immunize egregiously anticompetitive conduct harmful to consumers. In other instances, such as the safe harbor for "small" hospital mergers, they would immunize a broader range of conduct than is justified by economic efficiency. In addition, the proposed safe harbors do not include provision for any flexibility in their application, so that the federal enforcement agencies will be unable to respond to changed circumstances or unforeseen or extraordinary circumstances. One example of a possible unforeseen or extraordinary circumstance is conduct, through manipulation or otherwise, that technically falls within a safe harbor even though it clearly is not of the type that was intended to be protected.

1. Joint Activity by Twenty Percent or Fewer Health Care Providers in Market

The first safe harbor in Section 3 of the bills would exempt from the antitrust laws "[a]ctivities relating to health care services of any combination of health care providers" if the

number of providers involved does not exceed 20 percent of those of the same type or specialty in the "relevant market area."² This provision would immunize any conduct by health care providers that in any way related to the provision of health care services, so long as the providers did not exceed the statutory numerical limit. Because the safe harbor is written in terms of number of providers, it could exempt mergers and other joint activities of health care facilities with a combined market share far exceeding 20 percent. However, even if it were rewritten to exempt activities on the basis of market share, the safe harbor would be inadvisable.

The joint FTC/DOJ safety zone for physician network joint ventures, by contrast requires that the physician networks be financially integrated. Financial integration under the safety zone applies only to arrangements where the physicians participating in the network share substantial financial risk, which provides the participants with a common incentive to operate more efficiently and control costs, to the benefit of consumers. The proposed safe harbor would exempt from antitrust law enforcement a broad range of conduct, now considered per se illegal and in some cases criminal, that is harmful to consumers and has no countervailing procompetitive or other beneficial effects.

Under the proposed safe harbor, for example, a naked price fixing agreement among all or most of the obstetricians at a particular hospital, accompanied by threats of a boycott if a payer did not accept the providers' collectively determined prices and other terms of dealing, would be immunized if those involved in the anticompetitive activity comprised fewer than 20 percent of the entire area's obstetricians. The Commission addressed such a situation in the Southbank IPA matter.³

According to the Commission's complaint in Southbank, 23 obstetricians -- virtually all of the obstetricians practicing at the only hospital offering obstetrical services with which the HMO had contracted -- provided services to the HMO through an integrated IPA, in which the obstetricians shared financial

² H.R. 3486 uses a 25 percent of market figure for health care providers. These comments regarding the 20 percent figure used in S. 1658 apply also to the slightly higher figure used in H.R. 3486.

³ Southbank IPA, Inc., C-3355 (consent order issued December 20, 1991, 57 Fed. Reg. 2913, January 24, 1992).

risk.⁴ Allegedly, the obstetricians resigned from the integrated IPA and then formed Southbank IPA, which involved no financial integration among its members and offered no new or more efficient product to consumers. Through Southbank IPA, the obstetricians allegedly agreed among themselves on the prices they wanted from the HMO, as well as on various other terms of dealing. Contrary to a true integrated arrangement that can provide countervailing pro-competitive benefits, the collaboration among competitors who do not share financial risk does not offer such benefits. The obstetricians allegedly informed the HMO of their demands, refused to deal with the HMO other than collectively through the Southbank IPA, and commenced collective negotiations with the HMO to achieve their demands. Faced with a lack of obstetricians to provide services to its subscribers, and the inability in the short term to contract with, and rapidly switch its subscribers to, another convenient Jacksonville hospital that had obstetrical services and obstetricians available, the HMO twice was forced to capitulate to the Southbank IPA obstetricians' demands for a fee increase, according to the complaint.⁵ The increased costs of doing business were passed on to consumers in the form of higher premiums, the complaint alleged.

The 23 Southbank IPA obstetricians undoubtedly represented fewer than 20 percent of those practicing in the Jacksonville area. However, because the HMO had contracted with only a few local hospitals to provide its subscribers with all needed hospital services (a common occurrence among HMOs and certain other arrangements such as PPOs), the HMO was vulnerable to alleged collective action and threats of boycott. Under the 20 percent safe harbor in S. 1658 and H.R. 3486, the Southbank IPA obstetricians' alleged price fixing and coercive boycott threats would have been absolutely immunized from antitrust law enforcement.

A substantial number of past Commission law enforcement actions against alleged anticompetitive conspiracies harmful to consumers might well have been immunized from antitrust challenge if the 20 percent safe harbor had been in effect. These cases

⁴ The term "IPA" stands for Individual Practice Association. Typically, physicians in an IPA engage in capitation or other substantial financial risk-sharing and stand to share the benefit of gain or the risk of loss from the IPA's operation. When an IPA is financially integrated, it provides the participants with a common incentive to operate more efficiently and control costs, to the benefit of consumers.

⁵ This type of short-term marketplace disruption could be repeated by each group of medical providers if such conduct receives immunity under a safe-harbor.

frequently involved joint actions by a substantial percentage of providers at a particular hospital or other facility, even though the percentage they represented of the total number of providers in the area may have been much smaller.⁶ Specific market share determinations may not have been made in many such Commission matters, such as price-fixing and coercive boycotts involving naked restraints of trade unrelated to any legitimate joint venture, where a market power analysis is not necessary to establish anticompetitive effects and illegality of the conduct.

Finally, this proposed safe harbor would not effectively reduce health care providers' uncertainty about antitrust risks in their joint activities, or shield those activities from investigation by the federal antitrust agencies, because it frequently may be difficult to ascertain whether the 20 percent market share limit is met. In order to determine whether or not a particular joint activity meets this limit, the relevant product and geographic markets must be determined. Such a determination normally entails an extensive and detailed factual investigation, of the kind done most often in merger investigations. Thus, joint activities by health care providers would still be subject to antitrust investigation, with the accompanying uncertainty as to whether or not the activities and providers involved would ultimately be found to fall within the limits of the safety zone. In addition, significant new resources would need to be expended by the antitrust enforcement agencies in order to conduct such an analysis in every instance where the safety zone might apply. This would be an unfortunate use of limited Commission resources, particularly when expended with regard to joint activity, such as naked price fixing or coercive boycotts, that has no plausible procompetitive benefit to consumers.

⁶ E.g., Preferred Physicians, Inc., 110 F.T.C. 157 (1988) (consent order); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979) (consent order); Medical Staff of Doctors' Hospital of Prince George's County, 110 F.T.C. 476 (1988) (consent order); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988) (consent order); Medical Staff of Holy Cross Hospital, C-3345 (consent order issued September 10, 1991, 56 Fed. Reg. 49184 (September 27, 1991)); Medical Staff of Broward General Medical Center, C-3344 (consent order issued September 10, 1991, 56 Fed. Reg. 49184 (September 27, 1991)); Patrick S. O'Halloran, M.D., 111 F.T.C. 35 (1988) (consent order); Robert Fojo, M.D., C-3373 (consent order issued March 2, 1992, 57 Fed. Reg. 9258 (March 17, 1992)); Medical Staff of Memorial Medical Center, 110 F.T.C. 541 (1988) (consent order); Medical Staff of John C. Lincoln Hospital & Health Center, 106 F.T.C. 291 (1985) (consent order).

2. Activities of Medical Self-Regulatory Entities

This proposed safe harbor would immunize activities of a wide variety of physician groups relating to their setting or enforcing of "standards" that are "designed to promote the quality of health care provided to patients," so long as the activity is not "conducted for purposes of financial gain." If enacted, this safe harbor would appear to establish a broad and far-reaching exemption for anticompetitive activity, immunizing conduct that clearly is harmful to consumers. It has long been established that reasonable, bona fide self-regulation and information-generating activities do not violate the antitrust laws. The broad antitrust exemption contemplated by the bills is unnecessary and unwarranted, and the Commission strongly urges that it not be approved.

Experience shows that "quality of care" is often raised as a justification for anticompetitive conduct by health care providers, and has been advanced to support, among other things, broad restraints on price competition, restraints on the dissemination of truthful information, policies that inhibited the development of health maintenance organizations, and concerted refusals to deal. The immunity for actions "designed to promote the quality of health care" could immunize actions where an articulated quality goal was a pretext for, or coexisted with, a purpose to protect market participants from vigorous competition. Moreover, even if the standard setters are acting in good faith, actions based on flawed hypotheses or incomplete or erroneous information, and actions that are much broader than reasonably necessary to accomplish the desired goal, can injure consumers just as much as those where quality claims are in fact a pretext. As a result, the harm permitted by this provision is not limited sufficiently by the exclusion from the immunity of actions conducted for "financial gain."

Quality maintenance justifications have been made for a variety of broad competitive restrictions that are harmful to consumers. Under the proposed approach, a "quality" defense could have been asserted in virtually every health care case the Commission has brought. The Commission and the courts have considered these claims, but have rejected them when they were not supported by the evidence, or were not reasonably related to the harm sought to be prevented. This proposed safe harbor could permit a broad range of conduct harmful to consumers to escape the reach of the antitrust laws, based on quality assertions, without requiring any review of the validity of those claims or the actual effect of the conduct. The record of antitrust enforcement in health care markets by the Commission and others demonstrates the range of pernicious conduct that it could immunize.

For example, in American Medical Ass'n, the AMA asserted a quality-of-care defense. American Medical Ass'n, 94 F.T.C. 701, 1011-12, 1017 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd by an evenly divided Court, 455 U.S. 676 (1982). The AMA maintained that ethical prohibitions on various contractual arrangements -- involving fees that were lower than those usual for the area, were secured by underbidding another physician, involved reimbursement on a basis other than fee-for service, or precluded the patient's free choice of physician -- were necessary to prevent impairment of the doctor's medical judgment, "commercialism" in medicine, and deterioration of medical care. The Commission held that the restraints went far beyond what was reasonably necessary to attain the stated goals, and that they were designed in fact to prevent price competition among doctors. For example, based upon the evidence in the record of that proceeding, the Commission found that the purpose of the AMA's rule on "free choice of physician" was "primarily the anticompetitive one of suppressing the activities of competitors, rather than solicitude for the rights of patients." 94 F.T.C. at 1015.⁷

Quality of care claims also were raised in the Commission's Indiana Federation of Dentists case.⁸ In that case, the Supreme Court unanimously affirmed the Commission's order striking down an agreement among the Federation's members concertedly to refuse to submit x-rays to dental insurers for use in predetermination of benefits due under insurance policies. IFD had claimed that the challenged agreement was justified because it was necessary to protect patients from the possibility that insurers would make erroneous decisions on the least expensive adequate treatment. The Commission, in reviewing the record evidence concerning the basis for the Federation's actions, had noted that expressions of concern about preservation of the dentist-patient relationship coexisted with expressions of concern about the economic welfare of the dentists. 101 F.T.C. at 170. The Court concluded that

⁷ Cf. an earlier AMA criminal conviction for violating the Sherman Act by its efforts to impede the operation of an early HMO in Washington, D.C.: the AMA unsuccessfully attempted to justify its behavior based on its belief that HMOs were contrary to the public interest. American Medical Ass'n v. United States, 130 F.2d 233 (D.C. Cir. 1942), aff'd, 317 U.S. 519 (1943). The Commission's 1979 case concerned the AMA's continuation of ethical restrictions on physician participation in HMOs. See also Forbes Health Systems Medical Staff, 94 F.T.C. 1042 (1979) (consent order).

⁸ 101 F.T.C. 57 (1983), rev'd, 745 F.2d 1124 (7th Cir. 1984), rev'd, 476 U.S. 447 (1986).

IFD's argument was flawed both legally and factually.⁹ The Court stated that substantial evidence existed to support the Commission's conclusion that IFD's argument was not supported by any proof that consumers were harmed by insurers' use of x-rays in predetermination of benefits. Moreover, the Court characterized IFD's implicit claim -- that dentists could combine to refuse to provide patients with information because the patients might be led to make incorrect decisions -- as a frontal assault on the competitive policy embodied in the antitrust laws.¹⁰

The Commission's case against the Michigan State Medical Society, 101 F.T.C. 191 (1983), involved a different kind of refusal to deal: the threat that physicians would withdraw from participation in Michigan Blue Cross/Blue Shield insurance programs and Michigan Medicaid if their collective fee demands were not met. The Society argued that its actions, particularly those relating to Medicaid, were motivated by concern for the welfare of patients, because low reimbursement could lead to lower physician participation rates, forcing patients to seek less reputable providers. In rejecting this argument, the Commission pointed out that the Society had available to it legitimate public forums for expressing its views, and was not justified in resorting to organized boycott threats. 101 F.T.C. at 294-95.¹¹

In addition to immunizing expressed concerns for "quality of care", the bills would immunize peer review proceedings undertaken by a medical staff or medical association to evaluate "professional conduct," not merely the quality of care provided by medical professionals. Medical groups in the past have defined "unprofessional conduct" to include a wide range of procompetitive business activities, such as employment by HMOs, affiliation with non-physicians, and truthful advertising, on the

⁹ FTC v. Indiana Federation of Dentists, 476 U.S. at 461-64.

¹⁰ Cf. National Society of Professional Engineers v. United States, 435 U.S. 679 (1978), where the Supreme Court rejected a "quality" defense to a total ban on competitive bidding by engineers, which the Society had attempted to justify on the basis that competitive bidding would lead to deceptively low bids, which could cause engineers to perform inferior work. The Court held that the ban was overbroad as a protection against deception, noting, however, that professional deception itself was a proper subject for an ethical canon.

¹¹ Cf. FTC v. Superior Court Trial Lawyers Association, 493 U.S. 411 (1990), in which the Supreme Court rejected comparable arguments by providers of legal services.

assumption that these activities inherently lead to a lower quality of care. See, e.g., American Medical Ass'n, 94 F.T.C. at 1011-13, 1017. Thus, the bill could immunize boycotts and other sanctions against indisputably competent providers on the ground that the providers engage in disfavored competitive practices. See Forbes Health Systems Medical Staff, 94 F.T.C. 1042 (1979) (consent order) (exclusion of HMO physicians from medical staff).

The purpose of this discussion is neither to question the good faith of the medical organizations that support these bills, nor to suggest that the types of competitive restrictions discussed above necessarily will be reimposed if the bill becomes law. Rather, a broad antitrust exemption would take decision-making power out of the hands of consumers and place it in the hands of private professional groups, free from significant government regulation and from the constraints of the antitrust laws. This would not benefit consumers. As the Supreme Court has noted, the antitrust laws reflect a fundamental judgment that competition promotes quality as well as lower prices; that consumer choice, rather than the collective judgment of sellers, should determine the range and prices of goods and services that are available. See Professional Engineers, supra. Thus, the courts have refused to permit private groups of competitors to "preempt the workings of the market by deciding for [themselves] that [their] customers do not need that which they demand." Indiana Federation of Dentists, 476 U.S. at 462. The proposal, by immunizing conduct whenever it is claimed to promote quality of care, would allow physician organizations to impose their "views of the costs and benefits of competition on the entire marketplace." Professional Engineers, 435 U.S. at 695.

A broad antitrust exemption is not necessary to protect the public's interest in obtaining high-quality care. As the Commission has observed repeatedly, current law permits the collective efforts of physicians and other health care providers to promote quality, provided that such efforts are properly circumscribed to achieve that purpose, and thus do not unreasonably injure competition. Actions such as standard setting and certification, and more generally the publication of a professional group's opinion on issues affecting quality, do not restrain, and can in fact improve, the ability of consumers to choose among competing alternatives. Antitrust law already recognizes the right of competitors to provide information and express their opinion on quality issues. See, e.g., Schachar v. American Academy of Ophthalmology, 780 F.2d 397 (7th Cir. 1989). What is forbidden is for medical groups coercively to impose on the market their view of the level of quality that consumers should want.

Under current law, medical organizations can and routinely do engage in technology assessment, risk management, and development and implementation of practice guidelines or practice

parameters, activities that the bills are intended to protect. These standards will be accepted, and acted upon, by the public, hospitals, payers, government, and individual practitioners, in accordance with their intrinsic value and the respect accorded to the sponsoring organization. The public is not served in any additional way by permitting medical organizations to require adherence to these standards. It is more likely that such enforced adherence will stifle innovation, retard the progress of medicine, and unnecessarily limit consumer choice.

3. Hospital Mergers

This proposed safe harbor would exempt from the antitrust laws "activities relating to" a merger of two hospitals if one of those hospitals has 150 or fewer beds and an occupancy rate under 50%. The safe harbor would be a substantial and unwarranted expansion of the FTC/DOJ safety zone for hospital mergers.

The proposed safe harbor would make lawful anticompetitive mergers that are and should remain illegal -- indeed, some that either have been found, after a full trial, to endanger consumers, or that the Commission has found sufficient reason to believe warrant challenge, but which subsequently have been settled by consent agreements. This is most plainly illustrated by the enforcement record of the federal and state antitrust agencies. Of the nineteen successful or pending challenges to hospital mergers that those agencies have brought to date, more than a quarter of the mergers might have qualified for immunity¹² had the proposed safe harbor been in effect.¹³

¹² We say "might have qualified" only because, as discussed in more detail below at page 15, it is not entirely clear that transactions where the buyer and/or the seller controls more than one hospital (as is the case for all five of the transactions cited) would be eligible for the safe harbor.

¹³ These matters include American Medical International, 104 F.T.C. 1 (1984), a litigated matter in which the Commission found illegal a hospital chain's acquisition of its main competitor in a California market that gave AMI a market share in excess of 70%; a consent order prompted by another chain's acquisition of a hospital in Texas [Hospital Corporation of America (Forum Acquisitions), 106 F.T.C. 292 (1985)]; a settlement agreement obtained by the Washington State Attorney General concerning the merger of the only two hospitals in the Bellingham, Washington area [Memorandum of Understanding between the Attorney General for the State of Washington, the Sisters of St. Joseph of Peace - Health and Hospital Services, and St. Joseph Hospital (April 18, 1989)]; the consent order the Commission entered last year blocking Columbia Healthcare

(continued...)

The proposed safe harbor covers not only mergers of small hospitals (some already covered by the FTC/DOJ safety zone), but also mergers involving medium-sized hospitals with between 100 and 150 beds, such as those in most of the cases discussed above. The Commission and the Department of Justice excluded such hospital mergers from their safety zone, not only because such mergers have been challenged and found illegal, but also because hospitals with over 100 beds (as well as smaller hospitals with substantial patient volumes) do not usually share the characteristics that led the agencies to generally rule out challenges to mergers of smaller hospitals. For example, the agencies cited evidence that hospitals under 100 beds, with low patient volumes, may not share the efficiencies enjoyed by larger hospitals, but might be able to achieve those efficiencies through a merger. By contrast, the economic literature on hospital scale economies on balance indicates that hospitals in the 100-150 bed range already achieve most or all the efficiencies available to hospitals with more than 150 beds, leaving little room for improvement through merger.¹³ In short, there is no sound economic or efficiency basis for setting safe harbor thresholds high enough to cover medium-sized hospitals with up to 50% more beds than, and almost twice the patient volume of, the small hospitals now covered by the safety zone.

The bills' safe harbor also would apply to mergers of specialty hospitals (such as psychiatric or rehabilitation hospitals), not just of the general hospitals to which the current safety zone is limited. The vast majority of specialty hospitals are under 100 beds, but appear to compete efficiently and effectively at small sizes and patient volumes, in part because they are more specialized than most general hospitals. The generalizations that support the safety zone for general hospital mergers simply do not apply to specialty hospitals.

¹³(...continued)

Corporation's planned acquisition of a 120-bed hospital south of Orlando [FTC Docket No. C-3472, 58 Fed. Reg. 65721 (1993)]; and a pending matter in which the Commission has authorized the filing of a suit against a proposed hospital acquisition in Utah, where a hospital chain that owns two hospitals in the relevant market (each individually falling under the proposed safe harbor occupancy and size thresholds) would acquire hospitals from another chain [HealthTrust/Holy Cross, FTC File No. 941-0020. The Commission has temporarily deferred filing suit, pending staff's discussions with the parties].

¹⁴ See trial testimony of Monica Noether, Ph.D., Abt Associates, in Federal Trade Commission v. Columbia Hospital Corp., No. 93-30-Civ-FtM-23D (U.S. Dist. Ct. M.D. Fla. 1993) at II:118.

Moreover, the safe harbor does not expressly exclude, as does the parallel FTC/DOJ safety zone, newly-opened hospitals. As a result, established hospitals may be able to acquire new entrants of up to 150 beds, before they have had an opportunity to build their occupancy rates to above 50%.

The reliance of the safe harbor on "operational beds" (as opposed to the safety zone's use of licensed beds) raises two additional issues. First, the term "operational beds" is vague and undefined, leaving hospitals, enforcement agencies, and the courts at a loss as to whether that term means licensed beds, beds in service, or something else altogether. Second, the term "operational beds" may invite manipulation by hospitals, to the extent it permits them artificially to inflate or deflate bed counts for purposes of safe harbor qualification.¹⁵

Finally, the safe harbor leaves it unclear how to treat mergers involving, on either or both sides, multi-hospital systems. Are courts to construe the proposal's reference to "a merger of 2 hospitals" completely to deny eligibility to mergers involving hospital chains (a position the Commission and the Department of Justice have not taken with respect to the parallel language in their safety zone)? Or are they to find that ownership of a single small hospital by a large hospital chain acquiring another large chain immunizes the whole transaction -- even if the small hospital has no connection to the antitrust concerns raised by the merger? This is one example, among many, of how S. 1658 and H.R. 3486 burden the federal courts and the litigation process with clarifying issues that, under the current safety zones, can be rapidly and efficiently resolved by advice from the federal antitrust agencies.

4. "Good Faith" Negotiations

The seventh safe harbor in Section 3 of S. 1658 and H.R. 3486 covers "good faith negotiations to carry out any activity": (a) that is described in any of the bills' safe harbors (including any safe harbors subsequently adopted by the Attorney General under Section 4 of the bills); (b) that is the subject of an application for a certificate of review under Section 5 of the bills¹⁶; or (c) that is "deemed a submission of a notification"

¹⁵ Indeed, however bed capacity is measured, hospitals may have an incentive to add beds up to the 150-bed safe harbor limit (or keep open beds they otherwise would have closed) in order to artificially depress their occupancy rates below 50% and thereby qualify for the safe harbor.

¹⁶ The bills' provisions relating to issuance of certificates of review are discussed more fully in section B., immediately below.

under Section 6 of the bills.¹⁷ The precise scope of this safe harbor is not clear, but it is so broadly written (i.e., applies to "any activity," and has no limitation as to whom it applies or under what circumstances) that it could bring within its protection anticompetitive activity that actually goes beyond the conduct protected in the bills' other provisions. For example, while the bills' first safe harbor protects joint activities by health care providers who represent no more than 20 percent of those of a particular type in the relevant area, the "negotiations" safe harbor would appear to protect a blanket agreement among all the providers in the area as to how they were going to split themselves up by forming five unintegrated groups, each with 20 percent, in order that each would be exempt from the antitrust laws under the 20 percent safe harbor. Similarly, even though the notification provision of the bills (Section 6) itself does not create a safe harbor, but instead changes the antitrust standard of proof and limits damages for certain conduct, the negotiations safe harbor totally exempts from antitrust law enforcement, activity to "carry out" submission of such a notification.

B. Certificates of Review

Section 5 of S. 1658 and H.R. 3486 establishes an elaborate regulatory system whereby the Attorney General and the Secretary of Health and Human Services review applications by providers of health care services and issue certificates of review, which will confer antitrust immunity, to activities and arrangements that meet various criteria enumerated in Section 4(b) of the bills. The Department of Justice is also charged with a variety of ancillary functions, including continuing oversight of the activities of certificate holders in order to determine whether a certificate should be revoked.

The Commission concurs with the Department of Justice in objecting to the establishment, without justification, of such a costly, burdensome, and potentially harmful regulatory system to supersede the rational enforcement of traditional antitrust law standards in this area. In addition, it is probable that, as Assistant Attorney General Bingaman noted in her letter, institution of this regulatory system would divert substantial Department of Justice resources from more traditional antitrust enforcement activities.

¹⁷ The bills' provisions relating to submission of notifications are discussed more fully below.

**Notification Provisions Resulting in Changed Antitrust Law
Standard of Review and Reduced Penalties**

Section 6 of S. 1658 and H.R. 3486 appears to be based on the National Cooperative Research and Production Act of 1993 ("NCRPA"), which provides for modified antitrust treatment (most notably "rule of reason" assessment of legality, and single rather than treble damages) for certain joint ventures that disclose their proposed conduct to the Federal Government and the public, including some health care provider ventures. However, Section 6 extends the NCRPA framework to a broad range of health care provider activities, including conduct that is and should remain per se illegal and fully subject to the antitrust laws. Section 6 also permits some provider activities to enjoy the antitrust relief it affords without the providers ever actually notifying the Government or affected private parties of the activities, places sweeping and unreasonable restrictions on the admissibility of whatever information the Government does receive pursuant to that section, and does not adequately accommodate the Commission's need to receive and use such information.

It appears that Section 6 revisits issues that Congress addressed and resolved just last year in enacting the NCRPA. That Act extended its protections to some joint ventures for the production of goods and services, including some (but not all) ventures of health care providers. The legislative history of NCRPA specifically addresses its applicability to health care ventures, and indicates that the limited coverage of such ventures was intentional.¹⁸ Now, as then, there appears to be no legitimate need or justification for extending the NCRPA's antitrust relief to additional health care provider joint activities.

The most fundamental problem with Section 6 is that it omits important protections contained in the NCRPA on which it is modeled, that are needed to prevent extension of its antitrust relief to anticompetitive conduct rather than only legitimate joint ventures. Section 6, unlike NCRPA, is not limited to "joint ventures": it encompasses all "health care cooperative ventures," defined expansively to include "any activities . . . carried out by 2 or more persons for the purpose of providing health care services" (Section 10(4)). Such activities could include the most serious types of anticompetitive conduct, such as fixing the prices of such services, coercion of third-party payers or other purchasers to accept those prices, or boycotts designed to exclude competing providers from the market.

¹⁸ See S. Rep. 103-51, 103d Cong., 1st Sess. at 9.

The overly broad scope of Section 6 is compounded by its failure to incorporate provisions of the NCRPA that specifically deny antitrust protection to conduct that is unnecessary to make legitimate joint ventures work -- conduct that raises serious competitive concerns, often is per se illegal, and that may be subject to criminal prosecution. Thus, unlike NCRPA, Section 6 would protect: price-fixing and other agreements involving the production or sale of services by competing joint venture participants outside their venture; restrictions on the ability of joint venture participants to produce and sell services independently of the venture; exchanges of pricing and other sensitive information among joint venture participants, if not reasonably required to carry out the venture's purposes; and market allocations among competitors.¹⁹ In short, Section 6, unlike NCRPA, would extend the more liberal "rule of reason" standard of antitrust legality and reduced damage liability to blatantly anticompetitive conduct that in most circumstances is per se illegal under existing law.²⁰

A separate problem with Section 6 is that it may extend its antitrust relief in some cases even to conduct for which notification is deemed to have been submitted to the Department of Justice, but which is never actually disclosed to the Department or the public.²¹ This contrasts with the NCRPA, which

¹⁹ See 15 U.S.C. § 4301(b) (NCRPA provision specifically excluding such conduct from eligible "joint ventures").

²⁰ It has been suggested that providers would not seek Section 6 protections for clearly anticompetitive conduct, because disclosure of such conduct could prompt criminal prosecution. But the bill would reduce the likelihood of such prosecutions, not only by taking disclosed activities out of the category of per se offenses to which criminal prosecutions historically have been limited, but also, as discussed in more detail below, by extending Section 6 protections to conduct that is never disclosed, and by preventing or hindering the Government from using disclosed information against the submitter in a court of law.

²¹ Section 6(a)(2)(B). We say that Section 6 "may extend" its protections to undisclosed activities by ventures deemed to have filed a notification, only because it is unclear when (if ever) a particular activity would begin to enjoy such protections. Those protections take effect only after the publication of a Federal Register notice regarding the activity, or other events involving submission of actual notice. Section 6(b)(1)(B). Section 6's "deemed notification" of conduct for which there is no actual notice may thus confer only protections which will never take effect (unless the courts devise an

(continued...)

makes actual disclosure a prerequisite for its antitrust protections. Specifically, Section 6 automatically confers its protections, without requiring notice, on networks of "non-institutional providers" (such as physicians) (a) including less than 35 percent, or 50 percent (depending on whether the network is exclusive or non-exclusive) of the health providers and any specialty thereof in the relevant area, if (b) the networks engage in certain activities involving the sharing of financial risks.²¹

This feature of Section 6 is overbroad, in that it would extend its protections to all activities of a qualifying network venture, even per se illegal conduct unrelated to its central functions. But even for the network conduct that is directly related to more legitimate forms of cooperation, the legislation's 50% and 35% market share limits do not guarantee that a network joint venture poses no competitive dangers. The absence of actual advance notice to the government and the public would make less likely, or less timely, public and/or private challenges to the network ventures that do pose competitive dangers. Congress, in enacting the original National Cooperative Research Act in 1984, recognized that notification would facilitate antitrust challenges to potentially anticompetitive ventures, and considered that effect a reasonable burden for joint ventures to assume in seeking favorable antitrust treatment.²¹

In addition, Section 6 would impose unusual and unreasonably sweeping limitations on the admissibility of evidence obtained by the government in connection with notifications made under that section. Section 6(b)(5)(A) would render generally inadmissible, in any judicial or administrative proceeding, any information

²¹(...continued)

alternate standard for when Section 6 protections begin, to avoid effectively reading "deemed notification" out of the statute).

²² H.R. 3486 goes still further, extending automatic protection to ventures that satisfy either the market share or risk-sharing criteria, but not both (as is required by S. 1658), and also omitting the restriction in S. 1658 to non-institutional providers. H.R. 3486 therefore would extend automatic protection to networks which do nothing except fix prices (provided that the price fixing involves only a third or half of the providers, or any category thereof, in a market), as well as networks that involve some legitimate risk-sharing activities but also monopolize a market and thereby result in price increases rather than consumer benefits.

²³ See H. Conf. Rep. No. 98-1044, 98th Cong., 2d Sess. 17, reprinted in 1984 U.S. Code Cong. & Admin. News 3131, 3141.

contained in notifications.²⁴ Such information could be admitted only to "establish[] that a person is entitled to the protections" afforded by a notification.²⁵ These restrictions reach far beyond the much narrower evidentiary restrictions in the NCRPA, 15 U.S.C. § 4305(g). They also contrast with the absence of any restrictions on the admission into evidence of the often highly sensitive business information obtained by the federal antitrust enforcement agencies under the Hart-Scott-Rodino premerger notification statute, 15 U.S.C. § 18a.

There is no legitimate reason for barring admission in a judicial or administrative proceeding of the information provided in a notification, subject to appropriate protective orders. Section 6 would deny the Government use of information potentially relevant to a challenge to the venture for which notification is filed, as well as other transactions.²⁶

Moreover, Section 6's restrictions may invite submission of false or misleading information in notifications in order to discourage Government challenge of a venture, by making it impossible for the Government to use, in a criminal or other proceeding, such information to prove that the submitting party lied. The provision eliminates any significant danger of legal penalties for the submission of such false or misleading information.

²⁴ There is a parallel provision in the "certificates of review" provisions of S. 1658 and H.R. 3486 (Section 5(g)(3)), to which our concerns also apply.

²⁵ But the information could not be admitted to prove that a person was not entitled to Section 6's protections, an unreasonable disparity.

²⁶ Conceivably, Section 6 could be construed to prohibit the Government from using in court even independently obtained information identical to that contained in the notification (or to require a burdensome demonstration that the information sought to be admitted in fact was obtained independently).

Section 6 also requires submission of notifications only to the Department of Justice; by contrast, NCRPA requires that a copy of such submissions also be furnished to the Commission. Further, to the extent that Section 6 would permit information in notifications to be used at all in legal proceedings, it could be disclosed only in judicial proceedings, but not the administrative proceedings conducted by the Commission under Section 5 of the FTC Act, 15 U.S.C. § 45. Section 6(a)(4)(B).

Conclusion

In summary, the Commission believes that the special antitrust exemptions for health care providers contained in S. 1658 and H.R. 3486 are unnecessary and unjustified. Indeed, the bills would disserve the interests of consumers by immunizing from antitrust law enforcement many anticompetitive activities that increase prices or reduce quality, with no countervailing benefit to consumers. The bills also would create an unnecessary and unwieldy regulatory scheme, and would seriously undermine any health care reform effort that relies on competition to help improve the health care system's efficiency and to control costs. The Commission therefore strongly opposes enactment of S. 1658 and H.R. 3486 or any other legislation that contains the same changes to the antitrust laws.²⁷

By direction of the Commission, with Commissioner Owen dissenting.²⁸


Janet D. Steiger
Chairman

²⁷ The provisions of S. 1658 and H.R. 3486 also are included in identical or virtually identical form in S. 1770 and H.R. 3704 (the "Health Equity and Access Reform Today Act of 1993") introduced by Senator Chafee and Congressman Thomas and in S. 1743 and H.R. 3698 (the "Consumer Choice Health Security Act of 1993") introduced by Senators Nickles and Mack, and Congressman Stearns.

⁷⁸ Commissioner Owen dissents with the following comments:

While the Commission's letter stresses points of disagreement with the sponsors of the bill, and indeed, stretches to find them, I submit that there is universal accord on two fundamental premises. First, activity that is, on balance, anticompetitive -- a phenomenon that raises prices, reduces quality, and is otherwise harmful to consumers -- cannot be tolerated. Second, where the procompetitive efficiencies of a business combination outweigh its anticompetitive aspects, it is in the interests of consumers to allow that alliance to proceed. The issues presented in implementing these premises are delicate, but one would hope that reasonable people in government positions could disagree in good faith and amiable spirit, and with mutual respect, to further the crucial reform of health care that is underway.

While I have concurred in this agency's traditional opposition to most exemptions from the antitrust laws, see, e.g., Testimony of the Federal Trade Comm. Before the Subcomm. of Antitrust, Monopolies and Business Rights, Comm. on the Judiciary, U.S. Senate (March 23, 1993) at 14, I have also noted that, in the health care area, the current posture of the two federal antitrust agencies has been perplexingly schizophrenic. Furthermore, I believe that it is the prerogative of Congress to make any "demonstrably necessary changes" to the antitrust laws that, in its judgment, "facilitate the most efficient and socially acceptable mergers and joint activity in the health care industry." See Statement of Commissioner Deborah K. Owen on DOJ/FTC Antitrust Enforcement Policy Statements in the Health Care Area (Sept. 15, 1993) (hereinafter "Safety Zones Statement") at 6 n.8, 7.

The protestations of the Commission majority and the Antitrust Division over this bill are puzzling in light of the enforcers' own endorsement of other exemptions. The hospital merger safety zone adopted by both agencies, and from which I strongly dissented, is a blatant deviation from the well-tested principles of their Horizontal Merger Guidelines. Indeed, it may have claimed its first casualty when the Commission recently failed to fully investigate, and possibly challenge, a potentially anticompetitive hospital merger to monopoly. See Dissenting Statement of Commissioner Deborah K. Owen in the Matter of Columbia Healthcare Corporation (File No. 941-0005) (Feb. 7, 1994). Furthermore, the Antitrust Division has blessed the antitrust exemptions contained in the Administration's omnibus health care reform bill, which many believe represent a radical departure from the federal enforcement agencies' traditional stance in protecting consumers. See 66 Antitrust & Trade Reg. Rep. No. 1659 (April 14, 1994) at 414-16.

With this background in mind, the letters from the Commission and the Antitrust Division commenting on the bill become curiouser and curiouser. What principles, if any, guide their decisions as to which exemptions are acceptable, and which are not? Even more seriously, it is unclear how the agencies logically can object to the codification of their own enforcement guidelines, which presumably are grounded in solid economic and legal analysis. Indeed, if one has faith in the wisdom of the agencies' antitrust safety zones, then there is all the more reason, it seems to me, to apply them to private antitrust actions as well. I therefore disagree with my colleagues' assertion that there is no "sound justification for these exemptions." Commission Letter at 2.

The safe harbors in the proposed legislation are, by design, broader than the FTC/DOJ antitrust safety zones, see Section-by-Section [Analysis] of S. 1658, the Hatch-Thurmond Health Care Antitrust Improvements Act, at 3, although perhaps not as broad in all instances as the Commission would claim. At this time, I cannot confidently endorse any antitrust exemption that goes beyond the safety zones, nor can I endorse any codification of the merger safety zone that would exempt activity actionable under the Horizontal Merger Guidelines. Moreover, where it is not possible to effectively translate the statements of enforcement policy into legislative language, I would recommend that Congress err on the side of a narrower rather than a broader statutory exemption. At a future date, when the enforcement agencies have had more experience applying these doctrines, we will all be better able to evaluate proposals to broaden or otherwise modify any health care antitrust exemptions.

In addition to creating antitrust safe harbors, the draft legislation provides that in any action under the antitrust laws challenging certain "health care cooperative ventures," the defendants' conduct shall be judged under the rule of reason standard, and the plaintiffs' recovery shall be limited to actual damages and interest. Both Congress and the federal antitrust agencies have concluded, in the research and development and production contexts, that the specter of per se condemnation and treble damage liability may deter some innovative and procompetitive economic activity. See, e.g., Statement of the Antitrust Division (with the concurrence of the Federal Trade Commission) regarding the National Cooperative Research and Production Act of 1993 (NCRPA) (June 28, 1993) ("By improving the legal climate surrounding cooperative production activities, the NCRPA is intended to facilitate innovative and efficient joint ventures for production, as did the NCRA with respect to joint research and development ventures.") Without further investigation, I am unwilling to conclude, as the Commission does, that there are no appropriate joint ventures for the provision of health care services that merit similar treatment. At a minimum, however, I recommend modifying the draft

legislation to retain the per se standard and treble damage recovery for certain restraints that are readily identifiable, almost always tend to restrict competition, and have no plausible procompetitive justifications: naked price-fixing, bid-rigging, and market allocation agreements among competitors. In my judgment, this relatively simple amendment would neutralize most of the Commission's criticisms of this portion of the bill.

Finally, the Commission suggests that its record of "sound enforcement" in this area should be sufficient to reassure proponents of health care antitrust reform, a view that I have shared in the past. See Safety Zones Statement at 1, 6 n.8. Nevertheless, in light of the recent disagreement surrounding the Commission's hospital merger cases, see Columbia Healthcare Corporation (File No. 941-0005) (Feb. 7, 1994) (Commissioner Owen dissenting); HealthTrust, Inc. (File No. 941-0020) (March 22, 1994) (Commissioner Yao dissenting; Commissioner Owen not participating); Lee Memorial Hospital (File No. 941-0057) (April 26, 1994) (Commissioners Azcuenaga and Owen dissenting), the Commission may do well to reexamine its own direction. Some minor adjustments to the Commission's policies in this area may alleviate the impetus for the passage of antitrust exemptions, without sacrificing the legitimate interests of consumers.

[Note: The attachments to Ms. Steptoe's prepared statement are too voluminous to be included in the body of the hearing record. See appendix 1.]

Mr. BROOKS. Thank you.

Have you met Anne Bingaman? I think you all would have a warm relationship.

Ms. STEPTOE. Sometimes it is a mutual admiration society.

Mr. BROOKS. Next we have Dr. Merle Delmer. He is the Chair—I don't like that. I don't want to be a chair. Chairs have four legs. Dr. Delmer is chairman of the American Medical Association's Council on Legislation, appearing before the subcommittee on behalf of the AMA.

Doctor, we are delighted to have you. We will hear from you now.

STATEMENT OF DR. MERLE W. DELMER, CHAIR, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION

Dr. DELMER. Let me say I don't think of myself as a chair. If I were, I would be an overstuffed sofa. But I think you have identified where I am coming from and what I am here for. I do appreciate the opportunity to be here and address the committee.

The antitrust environment and its impact on the evolving health care delivery system is of great concern and interest to everybody. We believe that antitrust laws and enforcement activities must be modified, however, as a part of reform of our health care system.

What the AMA is seeking, quite simply, is a clarification of the laws, not a broad exemption. I repeat, not a broad exemption. The relief we seek is limited. It is designed not to protect fee-for-service, not to reduce competition, but to allow physicians to form networks and compete with insurance companies and large hospital holding companies that are out there in the field producing these products.

We are prohibited from doing that now. A number of legislative proposals would provide the antitrust clarification that physicians and patients need. Passage of such legislation would increase the number and quality of competitors in the health care field. The benefits go to the public automatically if you enhance competition.

We need antitrust reform now due to the rapidly changing health care market. If present trends continue, the health care marketplace will be dominated by for-profit corporate entities owned and operated by insurance companies and hospital holding companies.

For example, in my own State of Texas, known for its rugged individualists, managed care is growing by leaps and bounds, especially in the urban areas. At this time medical care is being rendered to approximately 70 percent of the citizens of Austin, TX, through the system of integration and consolidation that is occurring there.

Nationwide, the Big Eight insurance companies now own 44 percent of all the HMO's and PPO's, with the entire operational thrust creating even greater barriers to entry and precluding new competition. These corporate entities are typically managed by nonphysicians whose major focus seems to be the bottom line.

One need only look at the recent HealthNet case in which a patient was denied reimbursement for a bone marrow transplant recommended by her physicians. The litigation led to a damage award of \$89 million, and a husband and children were left mourning the loss of a wife and mother. That is just one example of placing business priorities ahead of patients' interests.

Other witnesses have said there is no empirical data to prove any of these points. On the contrary, such proof does exist. In fact, a recent study by the California Medical Association found that up to 31 percent of premium dollars are being spent by the insurance companies on profits, on administrative costs, on shareholder dividends, stock options, and bonuses to senior management.

With physician-sponsored plans, the savings go into patient care services. The Kaiser Permanente plan provides 95.3 percent of their premium benefit dollars to patient care. This experience shows that with physician-sponsored plans, the savings do go into patient care services, not into golden parachutes.

We are also including the testimony of eight attorneys who have assisted doctors in attempting to establish physician networks. In each and every case, the antitrust laws were cited as the major obstacle thwarting these efforts.

Ironically, we now find ourselves in the paradoxical position where antitrust laws are exerting a chilling effect on competition rather than nurturing it. Some assert that antitrust relief would reduce incentives to improve the quality of care.

To the contrary, allowing physician-sponsored plans will enhance quality. One of the proposed safe harbors outlined in each of the legislative proposals that you have under consideration would protect standard setting and enforcement activities by hospitals, peer review committees, and by medical societies that promote health care quality.

In a November 18, 1993, issue of the New England Journal of Medicine, Dr. Arnold Relman, the journal's editor emeritus, expresses his concern that the delivery of health care in America, as it moves from the independent practicing physician to a large integrated system, will be controlled almost entirely by giant for-profit organizations.

Dr. Relman asks, "How can we ensure that corporate financial goals do not unduly influence the behavior of physicians?" His answer is antitrust relief.

In conclusion, health care antitrust relief is needed as a part of broad health system reform to permit physicians to address the needs of today and properly respond to the changes we face. Appropriate solutions, such as those we have recommended, will contribute to the success of any model for health system reform that may be ultimately adopted.

My message is really this. Give us back our ability to improve health care quality for patients through appropriate antitrust reform.

Mr. Chairman, the AMA appreciates the opportunity to appear before your subcommittee. We look forward to working with you and the Congress to resolve these concerns. At this time, I request that my written and oral statements be submitted.

Mr. BROOKS. Without objection, so ordered.

[The prepared statement of Dr. Delmer follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

**Economic and Commercial Law Subcommittee
Committee on the Judiciary
United States House of Representatives**

Presented by

Merle W. Delmer, MD**RE: Antitrust Reform**

June 15, 1994

Mr. Chairman and Members of the Subcommittee:

My name is Merle W. Delmer, MD. I am a pathologist in San Antonio, Texas and Chair of the American Medical Association (AMA) Council on Legislation. Accompanying me are AMA General Counsel, Kirk B. Johnson, JD, and Hilary Lewis, JD, of the AMA's Division of Federal Legislation.

The AMA appreciates the opportunity to address this Subcommittee regarding the current antitrust environment and its impact on the health care delivery system, both in its present form, and as it will evolve in the future. We believe that the focus on health system reform in the 103rd Congress provides a singular opportunity to take action on a number of viable approaches for improving access to quality medical care. As various options are explored, a reexamination of federal antitrust law and enforcement policy as applied in the health care setting must occupy a preeminent role in the debate. In order to guarantee universal access to cost-effective health care, to assure the delivery of quality medical care, and to preserve the sanctity of the physician/patient relationship, it is imperative that the health care arena function as a meaningful competitive market.

Antitrust reform is needed now because of a rapidly changing health care marketplace. The proliferation of corporate entities owned and operated by insurance companies, hospital holding companies, and other for-profit corporations, will affect the practice of medicine to the detriment of individual patients and health care professionals alike. These corporate entities are typically managed by non-physicians and are focused on the bottom line. Under health system reform, this trend will accelerate.

However, this scenario can be prevented. Appropriate modification of the antitrust laws will enable physicians to reassert their traditional role as patient advocates, even in a health care arena dominated by managed care organizations. The market power of these organizations must be balanced by encouraging the formation of physician-directed health care networks. Physicians, with their knowledge and skill in clinical decisionmaking, can provide the expertise necessary to enable managed care entities to deliver quality medical care in the most cost-effective manner. Therefore, they must be accorded the ability to exercise their professional judgment to ensure that the highest level of care is rendered to patients enrolled in these organizations.

Physicians must be legally permitted to function in this decisive capacity, free from the current impediments that exist under antitrust law and enforcement policy of the Department of Justice (DOJ) and the Federal Trade Commission (FTC). Recognizing this problem, the DOJ and the FTC issued *Statements of Antitrust Enforcement Policy in the Health Care Area* in September 1993. These statements, however, do not address the current complexities in that the safety zones created require a high degree of integration before a physician network can meet antitrust requirements.

A number of legislative proposals, on the other hand, provide the antitrust clarification that physicians and their patients need. Passage of such legislation would clearly increase the number and quality of competitors in the health care marketplace, with obvious resulting benefits for patients.

THE AMA VIEW

As the following analysis indicates, the proposals for antitrust reform embodied in H.R. 3704, the "Health Equity and Access Reform Today Act of 1993," introduced by Representative William M. Thomas (R-CA), H.R. 3698, the "Consumer Choice Health Security Act of 1993," sponsored by Representative Cliff Stearns (R-FL), and H.R. 3486, the "Health Care Antitrust Improvements Act of 1993," introduced by Representative Bill Archer (R-TX), would create appropriate roles for all of the major groups in the health care industry and permit physicians to remain strong patient advocates through active participation in alternative models for health care delivery.

The medical profession is seeking clarification and modification of the antitrust laws, not an exemption. We have always maintained that price-fixing, boycotts, and other coercive practices should be subject to civil and criminal enforcement action by the regulatory agencies. It must be recognized that physician-sponsored networks can offer patients lower costs and higher value. Unlike insurance entities which divert a high proportion of premium dollars to administrative costs and corporate profits, physician-directed organizations are designed to focus assiduously on patient care services.

The antitrust relief that we seek would not permit physicians to restrict the services of other categories of providers. Anticompetitive behavior still would be subject to civil and criminal penalties. In fact, nearly every major health system reform bill contains provisions to assure access to a wide range of practitioners and to prohibit such discriminatory practices.

It has also been asserted that limited antitrust relief could reduce incentives to improve the quality of care. Under current law, antitrust litigation is traditionally instituted in an effort to circumvent quality of care sanctions resulting from peer review investigations. However, one of the proposed safe harbors outlined in the legislative proposals discussed herein would protect standard setting and enforcement activities by hospital peer review committees and medical societies that

promote health care quality.

Finally, antitrust clarification and exemption for the safe harbor activities outlined in H.R. 3704, H.R. 3698, and H.R. 3486 would stimulate incentives for competitive innovation. The Mayo Clinic, the Cleveland Clinic, and the Marshfield Clinic stand as the hallmarks for integrated multi-specialty medical groups that have been sponsored, organized, and run by physicians. These models represent examples of the most successful entities in providing quality medical care to vast numbers of patients at cost-effective prices. Physicians helped to create the nation's largest non-profit health insurance network and have been the greatest source of innovation in the delivery of health care services. It is certain that antitrust relief in this area clearly would benefit the public by increasing competition, by allowing the professionals most knowledgeable about patient care to direct health care networks and health plans, and by facilitating the formation of health plans that focus on patient interests.

ANTITRUST BARRIERS FACED BY INDEPENDENT PHYSICIANS

As independent physicians contemplate forming multi-specialty group practices, integrated delivery systems, and other health plans, they confront formidable barriers, both economic and legal. The federal antitrust laws stand as the greatest impediment to physicians in traversing this path.

First, independent physicians are foreclosed from organizing even simple health care delivery networks due to the *per se* illegality rules imposed by antitrust statutes. For example, if MSO physicians belonging to a managed services organization (MSO) agree on the fees and discounts to be offered as a PPO, they will be deemed to be engaged in *per se* illegal price-fixing. Notwithstanding a minimal hold on the relevant market, and complete inability to ever possess market power, such a conclusion would be reached. Since physicians generally do not have the accounting sophistication necessary to organize capitation and fee withhold arrangements, nor the necessary funds to make capitation successful, they cannot offer a PPO product that would be characterized as legal under

current antitrust doctrine. As a consequence, independent physicians must build simpler and cheaper network structures that will provide the experience needed to later create more complex networks. Yet the current antitrust rules virtually preclude their ability to act in this regard.

Once physicians can develop more sophisticated networks, such as PPOs that offer fee withholding arrangements, other antitrust obstacles are encountered. In order to be competitive, a wide choice of physicians, including physicians in various specialties, must be made available by a PPO. Generally, PPOs can maintain a competitive position by garnering 40 percent of the physicians in a market. A physician-sponsored PPO of this size, however, will face antitrust thresholds that are not confronted by insurance companies and other entities. On the other hand, an insurance company may organize a PPO containing 70 percent or more of the physicians in a relevant market without generating antitrust compliance problems, provided other organizations are not foreclosed from access to physicians.

Even more imposing are the antitrust hurdles facing independent providers in rural areas. The demographics in many parts of the country will not foster competition among large HMOs. Alternative forms of provider organizations would represent a viable option, but for the antitrust limits on the percentage of physicians in a market that can be involved in a physician-sponsored network. These constraints thwart the ability of independent physicians to form more efficient delivery networks in small cities and rural areas. Insurance companies, however, are not impeded by antitrust regulatory obstacles in forging similar enterprises.

LEGISLATIVE APPROACHES

The *Statements of Antitrust Enforcement Policy in the Health Care Area* issued by the Department of Justice and the Federal Trade Commission on September 15, 1993 represented an attempt to provide guidance to the health care industry on permissible activities under the federal antitrust laws that would steer and accelerate the operation of a competitive market. Unfortunately,

these statements fail to advance the formation of physician-directed health care delivery networks and health plans to effect wider patient choice. The AMA continues to discuss these matters with the DOJ and the FTC, and we look forward to resolving some of the remaining contentious issues.

While the agencies have indicated their commitment to ongoing review and supplementation of these statements, a legislative solution to the complex questions raised in this area remains imperative. The issuance of advisory opinions relating to physician joint ventures will offer some relief, yet many potentially beneficial enterprises will never be launched due to the specter of federal investigation and prosecution, prohibitive attorney fees, and treble damages imposed for failure to comply with the antitrust laws.

In our view, these problems can be addressed most effectively through the rational approaches offered in H.R. 3486, the "Health Care Antitrust Improvements Act of 1993," sponsored by Representative Bill Archer (R-TX), as well as H.R. 3704, the "Health Equity and Access Reform Today Act of 1993," introduced by Representative William M. Thomas (R-CA) and H.R. 3698, the "Consumer Choice Health Security Act of 1993," sponsored by Representative Cliff Stearns (R-FL).

The President's proposal, H.R. 3600, the "Health Security Act", introduced by Representative Richard Gephardt (D-MO), clearly recognizes the need for antitrust reform. In addition to granting fee-for-service physician networks to negotiate with health alliances, as does H.R. 3600, health system reform legislation also should permit collective negotiations with health plans.

H.R. 3704 (Thomas), H.R. 3698 (Stearns), and H.R. 3486 (Archer) would allow physicians to assume the critical competitive role appropriate in a health care system dominated by large corporate managed care entities. (For discussion purposes, this statement will address H.R. 3486, although we recognize that H.R. 3704 and H.R. 3698 would provide similar relief.) H.R. 3486, the "Health Care Antitrust Improvements Act of 1993," presents an interpretation of the antitrust laws that will facilitate the formation of health delivery networks and health plans organized by physicians.

The AMA believes that curtailment of the antitrust restrictions that presently have handicapped physician efforts will yield procompetitive results in allowing new entrants -- physician-directed entities -- into the market for health care delivery and finance. Physicians, who are uniquely qualified to provide health care more efficiently, whose skill and proficiency in clinical decisionmaking sets them apart from other corporate entities, and who are pledged to place patient needs foremost, must be permitted to compete in this arena.

1. Goals of Antitrust Reform

An analysis of health industry groups that will effectively participate in the developing structures indicates that most health care delivery networks and health plans of the future will be operated by insurance companies or hospitals, typically managed by non-physicians. Because these organizations likely will wield control in any given market, non-physicians will be exercising their authority in medical decisionmaking. This disturbing trend can be alleviated through the enactment of the "Antitrust Improvements Act of 1993," which will stimulate the development of a larger number of networks directed by physicians or other providers.

2. Development of Additional Competitive Models

H.R. 3486 recognizes that physician-directed networks and health plans can provide substantial benefits, particularly in a marketplace where the provision of insurance and health care services are being fused into a single product -- the prepaid health plan. In an increasingly complex environment of health care delivery networks and insurance companies with intersecting goals, the simple physician network can further competition by vying for contracts to deliver health care. Any network that unites price reduction with quality, in an effort to compete with insurers for health care delivery services purchased by self-insured employers, should be permitted to flourish.

The origin of physician-directed integrated delivery systems can be traced to the successful competitive benefits realized by the simpler network models. Integrated delivery systems can achieve

these competitive goals on a larger and more comprehensive scale by competing for contracts with insurers, competing with insurers for the business of self-insured employers, and competing also for the actual business of insurance. They do not require substantial administrative overhead and can, therefore, offer a competitive product at a lower cost. Successful examples of these systems can be cited in Los Angeles and Boston. In the former market, in which a majority of the population is enrolled in HMOs, the Mullikin Medical Centers represents a physician-directed health plan that has recently offered the lowest premiums.¹ Similarly, a physician-directed HMO in Boston is able to offer care to patients at some of the lowest prices in that market.²

Finally, physician-directed plans are more likely to act in a manner particularly sensitive to individual patient needs. For example, several insurance companies have incorporated the use of "optimal recovery guidelines" in determining appropriate lengths of hospital stay. These guidelines have been based on the top 10 percent of patient outcomes of those with the fastest and easiest recoveries, rather than from the average case.

Another area where business management priorities often prevail over patient interests is the approach to coverage and reimbursement determinations. Denial of coverage decisions have also brought about adverse consequences. The recent HealthNet case offers an egregious example of a patient who was denied reimbursement for a bone marrow transplant recommended by her physicians. The ensuing litigation led to an award of \$89 million in damages.

The lessons are clear. When prescriptive guidelines fail to consider individual patient needs and are implemented in a manner that impacts deleteriously upon patient care, negative consequences occur. That is why the AMA urges that physician involvement comprise an essential part of any health plan operation. Clearly, physician-directed health plans would provide the most direct avenue for such participation.

3. Antitrust and the Health Care Industry

It has been argued that the same antitrust standards should apply to health care as to all other industries. The fundamental tenet of antitrust policy -- that competition should be preserved and promoted -- must remain paramount. However, the AMA takes issue with the view that health care is like other industries, and that the same antitrust principles should apply. The staggering number of legislative proposals to substantially reorganize health care, pending in both Congress and the state legislatures, bears witness to the singularity of this industry in a number of respects. For example, the President's proposal, H.R. 3600, the "Health Security Act," would comprehensively revolutionize health care finance and delivery, the education of health care professionals, the regulation of quality, and virtually every other aspect of the industry.

The current imperative to guarantee universal access further distinguishes health care from those industries in which consumers are priced out of the market because they are unable or unwilling to purchase a product at the prices offered. As health system reform takes shape, and care will be provided to every citizen who needs it, a different set of imperatives should apply. Therefore, market dynamics to maximize quality, while containing costs, must be harnessed on behalf of a product that will be provided to all who need it.

No other industry faces this daunting challenge. In the legislative context, antitrust exemptions have been afforded to other industries that do not fit the usual mold. The insurance industry, farm cooperatives, labor union activities, public utilities, the securities and commodities industry, and communications companies have benefitted from statutory relief. Antitrust standards have also been modified on behalf of banks and other financial institutions. The insurance industry already reaps the benefits of a significant antitrust exemption that allows it a clear advantage in competing in the health care environment.

While the "Health Care Antitrust Improvements Act" would not create expansive waivers, it

would modify the interpretation of the antitrust laws with respect to physician networks and health plans to reduce barriers to their creation. It thus recognizes that health care delivery is now organized under a new set of assumptions: namely, that the concept of the individual physician as a solo entrepreneur has been supplanted by the physician as part of a large organization.

The interpretations offered by H.R. 3486 would not alter immutable antitrust principles. Obviously, antitrust laws must apply to physician-directed health care delivery networks. However, the focus must be changed to reflect the dynamic nature of the industry. Replacing antitrust laws with FTC/DOJ regulation was questionable even in endeavoring to fill the void created by federal judicial decisions in the 1980s. Development of industry regulations has not been the customary prerogative of the DOJ or the FTC. As the pace of managed care activity has escalated in recent years, the demand for a more coherent regulatory framework with substantial formal public input has increased. Although the aforementioned September 1993 guidelines signify a major step in this direction, many issues remain unanswered. The AMA believes that the "Health Care Antitrust Improvements Act of 1993" would provide the coherent regulatory structure and necessary formal public input to respond to outstanding issues.

4. Antitrust Remedies

The "Health Care Antitrust Improvements Act of 1993" would redress many of the problems outlined earlier with respect to independent physicians and other independent providers who seek to assume a constructive role in the new competitive strategies that are being formulated. The bill would establish the following four mechanisms: (1) a defined safe harbor for clearly procompetitive physician joint venture networks; (2) a mechanism for the creation of additional safe harbors for physician joint venture networks that prove to be procompetitive; (3) a procedure for certificates of review, whereby safe harbor status could be accorded to procompetitive individual joint venture networks; and (4) a procedure by which procompetitive physician joint venture networks that meet

certain size and financial risk-sharing requirements, but do not fall within a safe harbor, could be judged according to a rule of reason analysis and actual damages, rather than being adjudged as *per se* illegal and subject to treble damages.

The AMA supports these four carefully crafted provisions that would preserve the abiding principles of antitrust laws and also prevent anticompetitive abuse. Any possibility that a set of physicians acting in bad faith could injure competition is minimized.

a. Safe Harbors

H.R. 3486 contains seven safe harbors that would exempt the covered activities from the antitrust laws. Our testimony will focus on some of the safe harbors that apply to physicians.

The first safe harbor would exempt any activities relating to health care services of any combination of providers, if the total number of each type or specialty of the provider in question does not exceed 25 percent of the total number of that type or specialty in the relevant market area. Independent providers, therefore, could form simple networks without incurring antitrust sanctions. Networks that meet the 25 percent test could be constituted with virtual impunity, provided that all other statutory requirements are met.

This safe harbor bears little potential to result in abusive anticompetitive behavior. A combination of 25 percent of the providers in a market will not command sufficient market power to restrict output and raise prices. In addition, only a limited range of products can be successfully organized under this safe harbor. Because a viable PPO should be comprised of at least 40 percent of the physicians in a market, the networks organized pursuant to this safe harbor would have difficulty in competing for business with larger insurance company-organized PPOs, and could be better presented as steppingstones to more comprehensive health care delivery networks assembled by others.

The Department of Justice has raised concerns that the safe harbors may permit destructive

anticompetitive behavior, and that statutory safe harbors will become inflexible and not amenable to change if they prove to be inappropriate. But the scope of this proposed safe harbor is so limited that it will not present any serious threat to competition. While the risk will always persist for isolated individuals to act in bad faith for personal gain and, thereby, abuse a safe harbor, this must be balanced against the potential benefit of fostering the development of simple physician-directed networks. In this light, the possible abuses ebb in importance.

Although the Department of Justice argues against legislation on the grounds that regulatory guidelines are more susceptible to modification than Congressional action, H.R. 3486 empowers the DOJ to create and dismantle additional safe harbors. DOJ would also be authorized to grant certificates of review to individual networks. These provisions grant the flexibility needed to adjust to changing market conditions.

Section 4 of the Act would direct the DOJ to consider requests from the public for the designation of additional safe harbors. A number of factors would be weighed in determining whether a given proposal would promote or harm the operation of the market. The DOJ would be authorized to extend safe harbor status to specific kinds of networks or cooperative activities that have a demonstrably procompetitive effect on the market. The criteria employed grant additional flexibility to the Department in this area. With the advent of rapid consolidation and the compelling need to achieve cost savings, procompetitive conduct should not be hampered by legal uncertainty with respect to antitrust status.

The designation of additional safe harbors also will confer a benefit upon networks organized in small cities and rural areas. An evaluation of networking activities that are most conducive to expanded competition should serve as the starting point for any determination that a procompetitive combination comports with antitrust strictures.

Unfounded concerns have been raised regarding the potential for anticompetitive abuses under

the safe harbors. Because the authority to designate additional safe harbors resides with the DOJ and would be guided by criteria intended to serve the public interest, the potential for abuse under new safe harbors is slight. This potential can be mitigated further as the DOJ can always modify or eliminate a safe harbor that creates unforeseen consequences.

According to the Department, the process for creating additional safe harbors may result in the over-regulation of health care. Misgivings in this area may indeed be legitimate, but the Act envisions a structure whereby the Department, in conjunction with the FTC and the Department of Health and Human Services, is charged with the regulatory burden. By placing the initiative for the designation of additional safe harbors with providers, a coherent and interactive regulatory process between health care providers and the government would exist to ameliorate any risk of over-regulation. The AMA is confident that the agencies involved would act in good faith to implement their mandate, rather than paralyze the industry with excessive regulation.

Finally, it has been asserted that the bureaucratic process of designating additional safe harbors under H.R. 3486 may overburden the DOJ given its present resources. While this activity will require expanded work, providers who request a safe harbor would be required to meet the standards set forth in the measure and also persuade the Department that the public interest will be served through the creation of the proposed safe harbor. If additional staff is needed to handle this responsibility, the necessary resources should be provided. Health system reform will bring about the reorganization of one-seventh of our economy. Surely, a small number of new staff amounts to an insignificant price tag to assure that the reorganization proceeds smoothly and properly, with patient interests residing at the forefront.

b. Certificates of Review

Section 5 of the "Health Care Antitrust Improvements Act of 1993" would allow physician networks to apply to the DOJ for a certificate of review. If the certificate is approved, the network

would be secure from antitrust risk for legitimate, procompetitive activity. These certificates would be especially useful to networks organized in small cities or rural areas, as each region may present different market conditions. Rather than relying on a broad safe harbor, the certificate of review could authorize particular types of networks tailored to different markets.

Because the DOJ is granted the discretion to approve or disapprove of requests for certificates of review, it is unlikely that their issuance will have an adverse impact upon competition in any market. A certificate obtained through bad faith and abuse can be terminated. Nor does the certificate of review process create a potential for over-regulation. Once again, providers would initiate the requests for certificates. Those who are confident that their networks comply with the antitrust laws will not engage in the superfluous exercise of obtaining a certificate. Finally, this mechanism does not threaten to overburden the DOJ. Fifteen states have procedures that allow hospitals, and other categories of providers, to request "certificates of public advantage" or "certificates of review."³ In those states where the statutes are operational, the state agencies responsible for reviewing requests for certificates have not been overwhelmed.⁴ (ATTACHMENT B)

c. Notifications

Section 6 of the "Health Care Antitrust Improvements Act of 1993" would permit provider joint ventures to file a notification with the DOJ after an agreement to form such a venture is executed. The voluntary application process would subject the venture to rule of reason analysis in evaluating its legality under the antitrust laws. The rule of reason examination evaluates the venture's impact upon competition. Joint ventures that have filed notifications would not be deemed illegal *per se*, but they would have to prove that their activity will not pose any anticompetitive risk. This requirement diminishes the potential for anticompetitive abuse for two reasons. First, the DOJ would have the opportunity to review notifying joint ventures and prosecute those that it considered to be illegal. Second, private parties are also granted the right to institute claims against notifying joint

ventures.

Again, if any administrative burdens arise from notification filings, the AMA underscores its earlier recommendation that the DOJ be supplied with the necessary personnel to process these applications.

d. Deemed Notifications

Joint ventures that meet certain size and financial risk-sharing requirements would be deemed to have notified the DOJ without actually filing a notification pursuant to Section 6 of H.R. 3486. Rule of reason treatment would be extended to ventures that meet the outlined characteristics.

According to the requirements set forth in the measure, the joint venture must consist of a non-exclusive network of non-institutional providers not greater than 50 percent of the providers in the relevant market, in aggregate and by specialty. An exclusive network can be comprised of only 35 percent of the providers in the market in aggregate and by specialty. In addition, each member of the network must assume substantial financial risk for the operation of the venture, including, but not limited to, the acceptance of capitation contracts, the acceptance of contracts with fee withhold arrangements, or the holding by members of significant ownership or equity interests in the venture. The capital contributed by members must also be used to fund the operational costs of the venture, such as administration, marketing, and computer-operated medical information, provided that the venture develops and operates comprehensive programs for utilization management and quality assurance that include controls over the use of institutional, specialized, and ancillary medical services.

The AMA concurs with the application of a reasonableness standard to joint venture networks of non-institutional providers. Such networks are so likely to be pro-competitive that actual notification is not necessary. They may still be prosecuted by federal or state law enforcement agencies or by private parties if used for anticompetitive purposes.

A procompetitive network must be competitively viable by offering a wide choice of providers to patients in order to be competitive with insurance company networks that offer a wide choice. Such a network must include a large percentage of physicians in the market. Insurance company PPOs are generally nonexclusive, and they typically consist of more than 50 percent of the physicians in the market on their panels. In addition, the criteria for risk sharing add further assurances that the goals of the joint venture are procompetitive. PPOs that operate on a discounted fee-for-service basis would fall within deemed notification status by demonstrating a sufficient degree of integration to qualify. Members would have to invest money in the venture subject to risk of loss and the opportunity for a return of profit. The investment must also be used for purposes that indeed make the venture procompetitive.

Because the antitrust laws would apply to the joint ventures within the deemed notification category, with these enterprises precluded only from an adjudication of *per se* illegality, the potential for anticompetitive effect is nominal. The ability to sustain competition is further buttressed by the conservative thresholds of size that would be accorded rule of reason scrutiny. Finally, the DOJ and FTC would be engaged in their customary regulatory efforts, obviating any need for over-regulation.

CONCLUSION

The AMA strongly recommends changes to the current antitrust environment, particularly as health system reform will dictate the use of new competitive approaches for the delivery of affordable medical care. Managed competition will require the incorporation of substantial efficiencies, making cooperation among health care providers and coordinated activity on behalf of patients imperative. Health care antitrust relief will permit physicians to form networks to address the changes that will inevitably occur and provide valuable input into the policymaking activities of managed care plans. Appropriate legislative solutions, such as those now being considered, will contribute to the success of any model for health system reform that is ultimately adopted.

The AMA appreciates the opportunity to appear before this Committee. We will be pleased to respond to questions.

CONSOLIDATION IN HEALTH CARE MARKETS

Some examples of the growing consolidation of health care in a number of markets are summarized below:

Minneapolis. In Minneapolis, HMO penetration is even higher - 44% of local residents belong to HMOs. In the last year, 2 of the 4 biggest hospitals merged and 2 of the 4 dominant HMOs announced a merger. Employers and consumer advocates are concerned about the rapid consolidation taking place in the market. Barriers to entry are high and large capital reserves are required. In addition, without large numbers of patients, plans cannot attract doctors and hospitals; without doctors and hospitals, plans cannot attract patients. Leaders of the Business Health Care Action Group, more than a dozen Minneapolis-based employers (including Dayton-Hudson; Cargill Inc., General Mills Inc., Honeywell Inc. and Pillsbury Co.) who are otherwise free-market supporters, argue that health care should be viewed as a "kind of a public utility".

Los Angeles Area. The Los Angeles area, including the counties of Los Angeles, San Bernardino, Orange, Venture, and Riverside, has a population of about 14.5 million. The evolution of managed care is very advanced in this area. In fact, Los Angeles, is one of the most advanced managed care markets in the U.S. About 36% of the beneficiaries are enrolled in HMOs, and 35% in PPOs, for a total managed care market share of 71%. There are 32 HMOs and 30 PPOs operating in that market. However, just seven HMOs account for 7,030,000 beneficiaries. The largest HMO has an enrollment of 2,280,000, and the next largest has 1.6 million enrollees.

Albuquerque, New Mexico. The Albuquerque, New Mexico area has a population of about 612,000. The evolution of managed care is also very advanced in this market. Managed care plans have a 75% share of the insured population. Five HMOs cover 262,000 persons, and PPOs cover 88,000 beneficiaries.

Boston Area. The Boston area, including Essex, Middlesex, Norfolk, Suffolk, and Worcester Counties, has about 2.9 million people. Boston is relatively advanced in the evolution of managed care, but not as advanced as Los Angeles and Albuquerque. About 32% of the beneficiaries are enrolled in HMOs, and 21% in PPOs. There are over 12 HMOs and 20 PPOs. The five largest HMOs have 1,275,000 members. The largest HMO has 500,000 enrollees, and the next largest has 380,000.

Washington, D.C. Area. The Washington, DC area, including the District of Columbia, Northern Virginia, and Maryland, has about 3.7 million people. It is in about the same stage of evolution as Boston. About 26% of the population is in HMOs and 37% in PPOs. There are over 14 HMOs and 16 PPOs. The five largest HMOs have 1,030,000 of the beneficiaries. The largest of those HMOs has 450,000 members.

Chicago Area. The Chicago area, including the counties of Cook and DuPage, has about 5.9 million people. The evolution of managed care is not as advanced as in Los Angeles, Albuquerque, Boston, and Washington D.C. In fact, Chicago is at a relatively early stage, but the evolution is proceeding rapidly. About 22% of the beneficiaries are enrolled in

HMOs, and 30% in PPOs, for a total managed care enrollment of 52%. There are over 20 HMOs and more than 25 PPOs operating in the market. The five largest health plans, including HMOs and PPOs, account for 850,000 enrollees. The largest HMO has 370,000 -- relatively small considering the size of the market.

Atlanta Area. The Atlanta area, including Fulton, Cobb, Douglas, and Dekalb Counties, has about 1.7 million individuals. Atlanta is also at an early stage in the evolution of managed care. About 18% of the beneficiaries are in HMOs, and 48% in PPOs, for a total of 66%. There are 10 HMOs and 15 PPOs. The five largest HMOs have 460,000 beneficiaries, and the largest has 160,000.

**FIFTEEN STATE SURVEY OF LEGISLATION PROVIDING
FOR CERTIFICATES OF PUBLIC ADVANTAGE**

STATE	LEGISLATION	ADMINISTRATIVE COSTS	NUMBER OF APPLICATIONS
CO	Colo. Rev. Stat. Ann. § 24-32-2701 (West 1993).	According to Larry Wahl of the Colorado Hospital Association, the provision, which was passed last year, has not been implemented. Consequently, no funds have been allocated to administer the act.	The provision has not been implemented and has generated no applications.
FL	Fla. Stat. Ann. § 395.606 (West 1993).	Information not yet received.	Information not yet received.
IA	Senate File 380, amending Iowa Code Ann. § 96.3 (1993).	Barb Nervig in Iowa's Department of Public Health said that no rules have been promulgated yet. Consequently, no budget allocations have been made.	Because the act is not yet operational, no applications have been filed. However, several vertically integrated health care cooperatives are in the process of forming without immunity from antitrust liability.
KS	1992 Kans. Sess. Laws 158, amending Kans. Stat. Ann. § 65-425 (1992).	Chip Wheelen, the Kansas Medical Society's Director of Public Affairs, said that no budget allocations had been made nor applications filed as of February, 1994.	

ME	Me. Rev. Stat. Ann. Tit. 405-D §§ 1881-88 (West 1992).	According to John Dickens in the Health Planning Division of Maine's Department of Human Services, \$100,000 per year has been budgeted to sustain the program. It is administered by two half-time attorneys in the Attorney General's Office, one half-time analyst, and one half-time secretary. The act is self-funding; all hospitals in the state must make a yearly, pro rata contribution to the state to sustain the program.	To date, one certificate of public advantage has been issued. However, it has resulted in a great deal of strategic planning and networking on a regional basis. In addition, the Attorney General has provided legal assistance to hospitals considering availing themselves of the provision. John Dickens attributes the lack of applications to the "wait and see" attitude many hospitals have adopted in response to health care reform.
MN	Minn. Stat. § 62J.29 (1992).	<p>Nan Schroeder, a Division Director for the Minnesota Department of Health, estimated that she or another director will devote about 20% of her time to the project. In addition, the following resources and budget allocations would be required:</p> <ul style="list-style-type: none"> ● One full-time attorney ● One half-time research analyst ● Two full-time personnel positions (\$75,000-90,000) ● One economist on contract (\$40,000) ● Administrative law hearings (\$20,000) 	Only two hospitals have filed an application to date. David Renner at MMA attributes this to the expense and paperwork involved in the application process. In addition, most cooperative arrangements in Minnesota have been vertical, not horizontal, and have therefore not needed immunity from antitrust liability.

MT	1993 Mont. Laws 606.	Sam Hubbard of the Montana Health Care Authority reported that rules and regulations have not yet been promulgated. He does not know how much of the Health Care Authority's \$1.35 million budget will be allocated to this provision. He hopes that his staff of six full-time employees will be able to administer the program.	Because the act has not been implemented, there have been no applications filed. Montana has only four communities with more than one hospital. Several of these hospitals have expressed interest in the program.
NC	N.C. Sess. Laws 529.		Ann Hale of the North Carolina Medical Society said that the effectiveness of the provision has been questioned by some attorneys and the provision has not generated many applications.
ND	1993 N.D.SB 2295	Fred Larson in the State Health Department reported that the hearing on rules and regulations was held during the week of February 14, 1994. As a result, no budget allocations have been made. The rules and regulations should be in final form by May 1, 1994.	The provision has not been implemented and has generated no applications.
OH	Ohio Rev. Code § 3727.22 (1992).	Review of applications, issuance of certificates, and supervision under Ohio's Act are being handled by existing staff in the Health Department's Certificate of Need Division. No funds have been allocated under this provision.	According to Tom Moore in the Health Department, only two applications have been filed since the provision was implemented in April, 1993.

OR	S.B. 683 (Oregon Legislature)	Chad Cherial in Oregon's Office of Health Policy estimated that a biannual budget of \$50,000 would be required to draft rules, provide for review by the Attorney General's Office, allow for a public hearing, and process and monitor applications. In addition, .3 FTE's will be needed in the first year and .2 FTE's thereafter. Staff will be drawn from existing personnel.	Because the statute only applies to cooperative ventures in the realm of heart and kidney transplants, only three providers in the Portland area will be affected. No applications have been filed.
TN	1993 Tenn. Pub. Acts 331.	Three positions were created to administer the provision: an attorney, a health planner, and a secretary. In addition, one or two existing attorneys in the Attorney General's Office will be involved. The program is designed to be self-supporting with funds from application fees.	The act is not yet operational. However, according to Paku Khan, the Assistant General Counsel in the Department of Health, several parties have expressed an interest in applying for certification.
TX	1993 Tex. Gen Laws 638.	There has been no demonstration of costs yet for the Texas statute. Consequently, no funds have been allocated to the project. Tyrone Sharpe in the Department of Health anticipated that the \$10,000 application fee will fund three new positions (one in the Department of Health, one economist, and one liaison to the Attorney General's Office)	The provision will not be operational until March 1, 1994, so no applications have been received.

WA	Wash. Rev. Code § 39.34 (1993).	Tina Kondo in the Antitrust Section of the Attorney General's Office said that \$500,000 has been set aside for the statute's first two years. \$350,000 will fund the Health Services Commission, and \$150,000 is to go to the Attorney General's Office.	No rules have been promulgated and no applications have been received.
WI	Wis. Stat §§ 150.84 - 150.86	Steven Siegel in the Office of Policy and Budget said that no provisions have been made for staff or funding.	Colleen Wilson at SMSW said that no applications have been received. Although physicians and other providers have expressed interest in the statute, they have been advised that there may not be enough state involvement and supervision to avoid antitrust liability under <u>Ticor</u> .

ANTITRUST AND MANAGED COMPETITION

The health care industry finds itself in the midst of a revolution, with the dramatic consolidation of health care insurers and health care providers into unified entities that both finance and deliver health care. Physicians, hospitals, and other providers are being organized into comprehensive health care delivery networks that serve as the provider component of these plans.

These business arrangements focus on one primary objective -- the achievement of cost containment: (1) through the application of management techniques that cannot be employed when providers operate independently and without coordination; and (2) through the advantages rendered by economies of scale in assembling the maximum number of beneficiaries that can be managed within this framework. In this atmosphere, health care providers will be expected to work cooperatively so that the resulting structures are capable of rendering efficient, cost-effective, and quality health care. Only if physicians are accorded a meaningful role in this changing environment will we ensure that the commitment to our patients supersedes the financial goals of corporate plans.

1. The Consolidation of the Health Care Industry -- Background

The transformation of the health industry is being driven by compelling market forces and the desire for total reform of the health care system. The consolidation process is viewed as a means to develop enterprises that can reduce costs by organizing health care delivery in ways that are more efficient than conventional medical practice. This consolidation is occurring on a massive scale, with experts identifying the most efficient health plans as group or staff model health maintenance organizations (HMOs) with at least 450,000 enrollees who will maximize the use of a fully comprehensive health care delivery network dedicated to the care of their beneficiaries.⁵ While many areas of the country lack sufficient population to support competition between three or more health plans of this size, efficient HMOs of smaller sizes may succeed in competing in these locales. There is a potential, and a growing reality, that a small number of group or staff model HMOs will deliver all of the health care in any given market.

Many health care system analysts have theorized that competing health care delivery networks and health plans will be developed to deliver care in the future. In this construct, the most efficient networks will gain market share at the expense of their rivals. In fact, such consolidation already is taking place. Although HMO enrollment has steadily increased from 1980-1992, the number of HMOs peaked in 1987 with 650, and declined to 546 as of December 1992,⁶ as some HMOs have acquired others, and some have gone out of business entirely. In certain markets, more than 50 percent of health plan beneficiaries are enrolled in managed care plans, including HMOs and PPOs. A small number of health plans is accounting for a greater percentage of beneficiaries in those markets. Some of the areas seeing that have witnessed this trend include: Los Angeles, Albuquerque, Boston, Washington, DC, Chicago, and Atlanta. (ATTACHMENT A)

At first, extensive consolidation into such integrated systems appears to generate a spiralling phenomenon with providers tending to participate in many managed care plans upon their inception in a given market. Further evolution of managed care, however, usually results in many providers ultimately serving only a small number of plans. If current predictions are reliable, a reorganization of unprecedented scope is expected as several hundred thousand currently independent providers, including hospitals, other health care facilities, physician practices, and other health care professionals now engaged in independent practice perhaps will be organized into 5,000 to 10,000 health care delivery networks.

2. The Pace of the Consolidation

Although the consolidation process is proceeding rapidly, it will not be completed overnight. Delays in implementation probably can be attributed to lack of patient acceptance. Patients quickly become disenchanted when they discover that managed care plans restrict their freedom to be treated by the provider of their choice.

From an administrative perspective, the provider infrastructure for medical management of a plan's health care delivery network must attain a level of sophistication and knowledge critical to achieving efficiencies that will ultimately reduce plan premiums, yet maintaining quality. Finally, vast amounts of capital are needed to build managed care organizations in order to develop a provider network, administrative and information support systems. Clearly, management expertise and accumulation of capital require a concomitant investment in time, and these goals can overtake patient care needs.

Typically, consolidation in health care markets begins with a proliferation of simple networks and managed care products, such as indemnity plans that employ utilization review, and various kinds of preferred provider organizations (PPOs) offering incentives for beneficiaries to use a restricted panel of providers who have agreed to discount their fees. The surge of larger, more sophisticated managed care plans generally can be traced to the success of earlier, less sophisticated endeavors. In markets where large group or staff model HMOs dominate, this process has been documented.

3. Who Will Direct the Health Plans and Health Care Delivery Networks

Most health care system analysts have predicted that health care in the future will be delivered by "integrated" systems owned by insurance companies or other for-profit businesses, primarily accountable to their shareholders. A number of health care industry groups are positioning themselves to operate health plans or health care delivery networks that serve health plans. These groups include: (1) traditional insurance companies; (2) hospital holding companies, (3) corporate entrepreneurs; (4) large physician group practices; and (5) independent physicians in small group practices or in solo practice.

Success in this effort will require capital, experience in insurance or medical management, ownership or access to a significant component of a health care delivery network or health plan, and access to managerial talent as well. Large insurance companies obviously possess the greatest advantage in coordinating all of these segments. For example, the eight largest insurance companies own 45 percent of the nation's HMOs.⁷ Major insurance companies own 42 percent of the PPOs.⁸ These companies are in the process of building their health care delivery networks through strategies that contemplate: (1) the acquisition of HMOs and PPOs; (2) joint venture efforts to form HMOs and PPOs with existing integrated health care delivery systems; and (3) the acquisition or establishment of primary care physician practices.

Aetna Health Plans now operate 28 HMOs in 19 states, with a projected investment of one billion dollars in managed care over five years. Aetna also has decided to create its own primary care-oriented physician practices in several cities. Cigna Healthcare, which now has 42 HMOs in 27 states, is considering the purchase or creation of 400 physician practices nationally in a \$150 million program over 10 years. Prudential Health Care Systems, operating 28 HMOs in 18 states, is engaged in buying or establishing physician practices in several cities. Finally, Travelers Health Network, with 9 HMOs in 6 states, and Met Life Health Care, holding 14 HMOs in 14 states, have agreed to combine their managed care organizations into a joint venture initiative.

Similarly, hospital holding companies are well-positioned to develop and operate HMOs. Their favorable status is derived from owning the primary element of any health care delivery network -- hospitals. Through their relationship with hospital medical staffs, moreover, they have

access to the other integral factor in any network -- physicians. Investment capital, managerial talent, experienced medical management, and PPO and HMO operations are also available to hospital holding companies. At the present time, hospitals are building their health care delivery networks by organizing physicians on their medical staffs into physician hospital organizations (PHOs), affiliating with large physician group practices, and purchasing or starting primary care physician group practices.

For corporate entrepreneurs, capital and managerial talent are not in short supply, though experience in medical and insurance management may be lacking. Generally, their access to health care delivery networks is minimal. As a consequence, they usually acquire and manage physician practices.

Large multi-specialty group practices of physicians also enjoy advantages in owning a physician network, and either owning or being affiliated closely with a hospital. Thus, they can offer an integrated health care delivery network. Many even own and operate health plans. These large group practices also have access to managerial talent, substantial capital, and medical management experience. Some examples of large successful group practices include the Mayo Clinic and the Cleveland Clinic.

In this configuration, physicians in solo or small group practice constitute the most poorly positioned of the health industry sectors in creating health care delivery networks. Although they certainly have the potential to create networks that feature high quality of care and patient service, while minimizing annual per patient costs, they do not possess the requisite capital or managerial talent. Those physicians that are considered desirable for network participation, especially primary care physicians, are more likely to be solicited by hospitals and insurance companies to sell their practices or formally affiliate.

Independent physicians that do not want to accept such offers must, therefore, design new health care delivery systems in concert with others who are similarly situated. Management services organizations (MSOs) represent one vehicle by which these individuals may remain financially independent yet work with others. MSOs do not require a high capital investment or complex managerial experience. They do provide shared management services, such as billing, collections, scheduling, and purchasing to reduce the overhead costs to each physician. MSOs also perform medical management functions, such as utilization review, quality assurance, and coordination of referrals.

The network may be offered to self-insured employers or insurers as a PPO, or to those seeking to assemble a comprehensive health care delivery system. Successful MSOs can evolve into new multi-specialty groups of physicians through coordination of their practices and investments in other shared facilities, such as new clinics or outpatient surgery centers. That kind of success enables MSOs to attract capital and expand their functions. With more sophisticated management, they can affiliate with or acquire hospitals and, therefore, become more integrated delivery systems. The addition of insurance capabilities will eventually permit integrated delivery system to flourish into health plans.

1. Jacque J. Sokolov, MD, *Advanced Integrated Health Systems*, Health Care Advisory Board, Washington, DC (1994), page 30.

2. *Id.* at 39.

3. These 15 states are: Colorado, Colo. Rev. Stat. Ann. § 24-32-2701 (1993); Florida, Fla. Stat. Ann. § 395.606 (1993); Iowa, Senate File 380, amending Iowa Code Ann. § 96.3 (1993); Kansas, 1992 Kan. Sess. Laws 158, amending Kan. Stat. Ann. § 65-425 (1992); Maine, Me. Rev. Stat. Ann. tit. 22, §§ 1881-1887 (1992); Minnesota, Minn. Stat. § 62J.29 (1992); Montana, 1993 Mont. Laws 606; North Carolina, 1993 N.C. Sess. Laws 529; North Dakota, 1993 N.D. SB 2295; Ohio, Ohio Rev. Code Ann. § 3727.22 (1994); Oregon, SB 683; Tennessee, 1993 Tenn. Pub. Acts 331; Texas, 1993 Tex. Gen. Laws 638; Washington, Wash. Rev. Code Ann. §§ 39.34, 43.72.310, 70.44 (1994); and Wisconsin, Wis. Stat. §§ 150.84-150.86 (1992). The Oregon statute is limited to cooperative ventures for kidney and heart transplant services. The Florida and Kansas statutes are limited to rural cooperative health care delivery networks. The statutes in Colorado, Maine, Montana, North Carolina, Ohio, Tennessee, and Texas apply to hospitals or health care facilities only. The remaining statutes -- Iowa, Minnesota, North Dakota, Washington, and Wisconsin -- apply to cooperative ventures or organized health delivery system cooperatives created by any kind of provider.

4. The AMA has surveyed the fifteen states involved to determine the regulatory burden that has resulted from these statutes. The survey results are attached. (Attachment B)

5. Richard Kronick, PhD, David C. Goodman, MD and John Wennberg, MD, "The Demographic Limitations of Managed Competition, *New England Journal of Medicine*, January 14, 1993.

6. David E. Vogel, *The Physician and Managed Care*, American Medical Association (1993), page 19.

7. Harris Meyer, "Insurance Giants Bet on Managed Care," *AM News*, February 7, 1994, page 3.

8. *Marion Merrell Dow Managed Care Digest: HMO Edition 4* (1993), note 8, page 4.

Mr. BROOKS. The subcommittee would next hear from Scott McGlothlen, American Association of Nurse Anesthetists.

**STATEMENT OF SCOTT MCGLOTHLEN, AMERICAN
ASSOCIATION OF NURSE ANESTHETISTS**

Mr. MCGLOTHLEN. Thank you very much for the opportunity, Mr. Chairman.

Over 25 years ago I started in the health care field in a hospital in Chairman Brooks' district. I am now in private practice as a certified registered nurse anesthetist, CRNA, and have—

Mr. BROOKS. Let me just comment. As you know, of course, Mr. McGlothlen attended Lamar University and the Baptist School of Nursing in Beaumont, TX. He has good credentials, a wonderful education. When I was in the State legislature some 45 years ago, I helped make that a 4-year university. He is a typical graduate of Lamar University: hard working, dedicated, successful.

Mr. MCGLOTHLEN. Thank you very much, Mr. Chairman.

Over 25 years ago, I started in the health care field in a hospital in Chairman Brooks' district. I am now in private practice as a certified registered nurse anesthetist, CRNA, and have clinical privileges in several Colorado hospitals, including one in Congresswoman Schroeder's district.

I was chosen to represent the 26,000 members of the American Association of Nurse Anesthetists, AANA, today, because I wouldn't be in private practice as a CRNA if it weren't for the current Federal antitrust laws.

AANA's testimony includes numerous antitrust cases brought by CRNA's. For example, in *Oltz v. St. Peter's Community Hospitals*, several anesthesiologists threatened to leave the hospital unless CRNA Oltz's independent billing status was terminated. The hospital terminated Oltz's billing contract. With Oltz gone, the anesthesiologists' annual earnings increased 40 to 50 percent. Oltz sued under section 1 of the Sherman Act. The anesthesiologists settled before trial, paying Oltz \$462,500.

I was one of the plaintiffs in another case cited in the testimony, *Anesthesia Advantage, Inc. v. Metz*. In 1983, Humana Hospital in Aurora, CO, sought anesthesia coverage for their obstetrics department. The two anesthesiology groups within the hospital declined to provide the OB coverage. So the hospital gave a group of CRNA's, including me, independent clinical privileges to the hospital to provide OB coverage.

By mid-1984, the OB anesthesia practice was flourishing. Surgeons were also requesting the CRNA's to provide anesthesia for their surgical patients. By late 1984, the two anesthesiology groups had changed their mind and wanted the CRNA group to share the OB practice on their terms. The two anesthesia groups also did not want the CRNA's to cover surgery cases. The CRNA groups refused.

The two anesthesiology groups then conspired to take over the CRNA practice and pressured Humana Hospital to join the conspiracy. First, in the spring of 1984, one of the anesthesiologists developed an obstetric anesthesia call schedule, which effectively restricted the days CRNA's could cover. In addition, the anesthesiologists voted in April 1986 to limit the independent clinical privileges of CRNA's and to require direct supervision by an anesthesiologist of the provision of OB anesthesia by CRNA's. In June 1986 the anesthesiologists and the hospital administrator agreed that CRNA's would not be allowed to provide anesthesia services in the hospital unless an anesthesiologist did not want to do the case.

Second, one of the anesthesiology groups conspired to induce another hospital to reject a proposal by the CRNA group to provide outpatient ambulatory surgery anesthesia as independent contractors. The anesthesiology group had also submitted a proposal for anesthesia coverage and urged the hospital to have the CRNA's fired.

Third, the anesthesiologists induced a third hospital to reject the CRNA's proposal that the hospital use the CRNA's for OB anesthesia.

In June 1986 the CRNA's brought suit against the anesthesiologists and Humana Hospital, alleging violations of the Sherman Act. In August 1986 the CRNA group was dismissed from Humana Hospital. The case proceeded all the way to the Tenth Circuit Court of Appeals level, on a jurisdictional issue.

In 1990, the Tenth Circuit found that the anesthesia services involved in this case did affect interstate commerce and remanded the case for further proceedings. In 1991, the defendants paid the CRNA's \$95,000 to settle the case. In addition, the defendants agreed in writing that they would not interfere in the future with CRNA's right to practice anesthesia.

The settlement worked. Today I have independent clinical privileges at several hospitals. When we filed our suit in 1986, the trend in Colorado was against private practice CRNA's. Now there are many private practice CRNA's in Colorado, competing with anesthesiologists. I am firmly convinced here today, had it not been for the antitrust case, I would not have those privileges.

Our case had a favorable impact on consumers as well. My fee for an OB anesthetic is a flat \$360. If a patient has an OB anesthetic provided by an anesthesiologist, it costs \$600 to \$900.

The AANA opposes the provisions in H.R. 3600 which would grant an antitrust exemption to provider groups to collectively negotiate with regional alliances over fee schedules to be paid under fee-for-service plans for several reasons. The primary one is that it fails to provide for any real supervision or provider conduct during the fee setting and fee negotiation process. Therefore, members of our association, having less negotiating power than dominant provider groups, risk being ignored or excluded.

Like physicians, CRNA's are concerned about the potential power of proposed regional alliances and health plans. However, based on experience, members of my profession and other nonphysician providers are equally concerned about the power of physicians. Weakening the antitrust laws will weaken the ability of nonphysicians

to compete with physicians. It will also weaken a patient's ability to choose.

While there may be a need to clarify the existing antitrust laws even more than was done in the September 1993 Department of Justice/FTC antitrust guidelines, there is no documented need to change the antitrust laws. Therefore, the AANA opposes any changes in the current antitrust laws.

Thank you for this opportunity, Mr. Chairman.

[The prepared statement of Mr. McGlothlen follows:]



**AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
ANTITRUST TESTIMONY
HOUSE JUDICIARY COMMITTEE
June 15, 1994**

The American Association of Nurse Anesthetists (AANA) is the professional association that represents over 26,000 certified registered nurse anesthetists (hereinafter "CRNAs"), which is 96 percent of the nurse anesthetists in the United States. The AANA appreciates the opportunity to provide testimony regarding our opposition to any weakening of the current antitrust laws. We believe that the current antitrust laws and enforcement are crucial to protect competition and consumer choice in the health care system.

INTRODUCTION

In the administration of anesthesia, CRNAs perform the same functions as physician anesthetists (hereinafter "anesthesiologists") and work in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons; ambulatory surgical centers; health maintenance organizations; preferred provider organizations; and U.S. Public Health Service, Veterans Administration, and military medical facilities. Existing studies demonstrate that the quality of care administered to patients by CRNAs and anesthesiologists is the same. Anesthesia outcomes are affected by such factors as the provider's attention, concentration, and organization, and not whether the provider is a CRNA or an anesthesiologist. That is why the Harvard Medical School Standards in Anesthesia focus on monitoring the patient; the

standards are based upon data that indicate that anesthesia incidents are usually caused by lack of attention to detail and insufficient monitoring of the patient.

As anesthesia specialists, CRNAs administer more than 65 percent of the 26 million anesthetics given to patients in the United States each year. CRNAs are the sole anesthesia providers in 85 percent of rural hospitals, enabling these medical facilities to provide obstetrical, surgical, and trauma stabilization services. CRNAs are also front line anesthesia providers in underserved urban areas, providing services for major trauma cases, for example.

While many CRNAs practice in an anesthesia team which includes anesthesiologists and other ancillary support staff, CRNAs also practice as independent providers. Independent CRNAs must compete with anesthesiologists in the marketplace. For this reason, CRNAs have found it necessary to seek the protection of antitrust laws to guard their ability to offer competitive anesthesia services to the public. In light of the power and influence of the medical community, weakening of the antitrust laws would have a negative impact on the ability of CRNAs to compete with anesthesiologists.

HISTORICALLY, SOME ANESTHESIOLOGISTS HAVE ATTEMPTED TO ELIMINATE CRNAS AS COMPETITORS

Before the end of the nineteenth century, surgery had been performed only when death was otherwise certain. By the end of the nineteenth century, two developments - the discovery and utilization of anesthesia and the discovery and development of asepsis - resulted in an enormous expansion of the numbers and types of surgeries performed. Consequently, hospital construction flourished as the need grew for operating rooms to accommodate aseptic surgery.

Simultaneously, demand grew for anesthesia specialists to focus their attention on the anesthesia care of patients while a physician performed surgery.

To meet their ever increasing need for dedicated and qualified anesthetists, physicians turned increasingly to sisters in Catholic hospitals. Nursing sisters, as well as other registered nurses from a growing number of nurse training programs, practiced anesthesia with wide acceptance.

World War I accelerated the demand for qualified nurse anesthetists. The U.S. government called on all available resources to educate nurses who were needed to provide anesthesia to wounded troops. Advances made in anesthesia administration and nurse anesthesia education during the war contributed to the nurse anesthetists' dominant position in the anesthesia services field.

Even before World War I, however, the growth and acceptance of the nurse anesthesia profession and its training programs provoked anticompetitive reactions from anesthesiologists. In 1911, in a harbinger of future anti-nurse anesthetist activity, counsel for the New York State Medical Society declared that the administration of an anesthetic by a nurse violated the law of the State of New York. The following year, the Ohio State Medical Board passed a resolution stating that only registered physicians could administer anesthesia.

Early efforts to crush the nurse anesthesia profession gained momentum as anesthesiologists organized in their opposition to nurse anesthetists. In 1915, anesthesiologists founded the Interstate Association of Anesthetists (IAA). In 1916, the IAA successfully petitioned the Ohio State Medical Board to withdraw recognition of Cleveland's Lakeside Hospital as an acceptable training school for nurses, and to deny recognition of its graduates as registered nurses, on the grounds that Lakeside's use of nurse anesthetists violated the Ohio Medical

Board Acts. Nurses and prominent surgeons alike protested the board's decision, and succeeded in having it reversed.

Similarly, in 1917, the Kentucky State Medical Association, with prompting from organized anesthesiologists, passed a resolution prohibiting members from employing nurse anesthetists or referring cases to hospitals where nurse anesthetists practiced. In a test lawsuit brought by a nurse anesthetist, the Kentucky Court of Appeals ultimately rejected the proposition that the administration of anesthesia by a nurse directed by a physician constituted the unauthorized practice of medicine.

In 1921, another anesthesiologist group, the American Association of Anesthetists, commenced a boycott by adopting a resolution prohibiting its members from teaching nurse anesthetists. Anesthesiologists also moved into the political arena, supporting legislation which would prohibit qualified nurse anesthetists from administering anesthesia.

Unlike anesthesiologists, the American College of Surgeons, comprised of physicians who utilized anesthetists, opposed legislative prohibitions of nurse-administered anesthesia. In a 1923 resolution, they opposed all legislative enactments which would prohibit qualified nurses from administering anesthesia.

Surgeon support of nurse anesthetists, however, did not stop the anesthesiologists' efforts to keep nurse anesthetists from practicing their profession. In 1933, the anesthesia section of the Los Angeles County Medical Association, along with two individual anesthesiologists, brought a lawsuit against a nurse anesthetist. Notwithstanding an opinion from the California attorney general that supervised nurse anesthesia was not the practice of medicine, the physicians claimed that nurse anesthetists' administration of anesthesia constituted the illegal practice of

medicine. As had other courts, the California court found that the administration of anesthesia under physician direction and supervision was not the practice of medicine.

In 1937, the American Society of Anesthesiologists (ASA) was formed. (The American Association of Nurse Anesthetists had been founded in 1931). Immediately after its inception, the ASA presented a master plan for the eventual elimination of nurse anesthesia to the American College of Surgeons. The plan specified that nurses should not be permitted to continue to provide anesthesia. It also provided, inter alia, that a provision should be included in the Minimum Standards of Hospitals (the forerunners of the Joint Commission on Accreditation of Hospitals' standards) directing that the department of anesthesia in each hospital shall be under the direction and responsibility of a well-trained physician anesthetist. The plan cautioned, however, "that no legislation should be forced until physician anesthetists can take over the work in a competent way."

World War II increased the number of anesthesiologists. After the war, the anesthesiologists, as they sought to establish themselves in a civilian economy, renewed their activities against CRNAs. Between 1946 and 1948, the ASA launched a campaign to discredit CRNAs in the eyes of the public. The campaign was successful in reducing the numbers of nurses attending nurse anesthesia training programs. The campaign was halted when the American Medical Association, the American College of Surgeons, and the Southern Surgical Society expressed their opposition to the ASA's negative publicity, and expressed their support of, and continued intention to utilize, CRNAs.

In 1947, the ASA adopted an "ethical principle" prohibiting members in good standing from participating in nurse anesthesia programs and from employing or utilizing CRNAs. Measures

to enforce the ethical guidelines included the threat to revoke the American Board of Anesthesiology certificates of physicians training nurse anesthetists.

SUCCESSFUL ANTITRUST RELIEF AGAINST ANESTHESIOLOGISTS

CRNAs have successfully prosecuted actions against anesthesiologists for antitrust injury. Appellate Courts have recognized that CRNAs and anesthesiologists can be direct competitors for antitrust purposes. Bahn v. NME Hospitals, 772 F.2d 1467, 1471 (9th Cir. 1985). For example, in Oltz v. St. Peter's Community Hospital, 861 F.2d 1440 (5th Cir. 1988), plaintiff Oltz sued four anesthesiologists and the hospital that granted three anesthesiologists an exclusive contract to provide anesthesia services, alleging violations of section 1 of the Sherman Act. The anesthesiologists settled before trial, paying Oltz \$462,500.

In affirming the district court's finding that the hospital joined the conspiracy to terminate Oltz's billing contract with the hospital, the Ninth Circuit noted that the anesthesiologists had "pressured the hospital at St. Peter's to eliminate Oltz as a direct competitor." The anesthesiologists had threatened to leave St. Peter's unless Oltz's independent billing status was terminated. After Oltz's termination, the anesthesiologists offered him a salaried position as an employee in their association, under their direction. Oltz refused. With Oltz gone, the anesthesiologists annual earnings increased by forty to fifty percent. The public interest in competition was vindicated by Oltz's invocation of the antitrust laws.

One Appellate Court specifically addressed the issue of whether anesthesia affects interstate commerce, a prerequisite to relief under the Sherman Act. In Anesthesia Advantage, Inc. v. Metz, 708 F. Supp. 1171, 1175 (10th Cir. 1990), four nurse anesthetists in the Denver, Colorado area and their professional corporation, "The Anesthesia Advantage, Inc." (TAA),

brought suit in June of 1986 against several anesthesiologists and their professional corporations, as well as Humana Hospital of Aurora. The plaintiffs alleged violations of section 1 of the Sherman Act in that 1) the hospital had instituted a "call schedule" for anesthesiologists and that the hospital's anesthesiology staff recommended the adoption of guidelines for supervising nurse anesthetists; 2) the defendants conspired to induce another hospital to reject a fee-for-service proposal by TAA to provide out-patient ambulatory surgery anesthesia on pre-arranged days; and 3) the defendants induced a third hospital to reject TAA's proposal that the hospital use TAA for an obstetric epidural anesthesia program. In August of 1986, the CRNAs were dismissed from Humana Hospital. The plaintiffs claimed that they were "illegally squeezed out of business by anesthesiologists because the presence of CRNAs forced down the market price for anesthesiologist services".

The trial court granted defendants' motion for summary judgment and dismissed the CRNAs' claims for lack of subject matter jurisdiction, concluding that they had failed to demonstrate a sufficient economic connection between the unlawful conduct and interstate commerce. The Tenth Circuit Court of Appeals found that the CRNAs had made an adequate showing of jurisdiction at the summary judgment stage by alleging that one or more of the defendants had out-of-state shareholders; that defendants purchased equipment and supplies from out-of-state vendors; that both defendants and plaintiffs received reimbursement from out-of-state insurance companies; and that both defendants and plaintiffs treated out-of-state patients. Therefore, the Tenth Circuit Court of Appeals reversed the judgment of the district court and remanded the case for further proceedings. In 1991, the defendants paid the CRNAs \$95,000 to settle the case. In addition, the defendants agreed in writing that they would not interfere in the future with the CRNAs' right to practice anesthesia.

Relief under state antitrust laws was granted in State of Maine v. Anesthesia Professional Association, 1984-2 Trade Cas. (CCH) 66,081 (Me. Super. Ct. June 28, 1984). The defendants in the case, the Anesthesia Professional Association (APA) and 19 of its member anesthesiologists, entered into a consent decree with the State of Maine resolving certain issues concerning the anesthesiologists' practice of anesthesiology in Portland, Maine area hospitals. The consent decree prevented the defendants from taking key employment related actions against CRNAs. The relief protecting CRNAs was effective because the consent decree also prohibited the APA and its member anesthesiologists from entering into an exclusive contract with any hospital for the provision of anesthesia services. Thus, the APA anesthesiologists could not monopolize anesthesia services at the hospital at the expense of CRNAs (and other competing anesthesiologists).

The Federal Trade Commission (FTC) has also fashioned effective relief to remedy the ASA anticompetitive activities. In re American Society of Anesthesiologists, 93 F.T.C. 101 (1979). The Commission and the ASA entered into a consent order under which the ASA agreed to end its formal restrictions on methods of anesthesiologist compensation. In the case, the ASA's "ethical guidelines" prohibited anesthesiologists from practicing on any basis other than fee-for-service, i.e., members were not to practice as salaried employees of hospitals. Id. at 102.

The Commission's order in that case, inter alia, prohibited the ASA for a 10-year period from making any statement containing an official ASA position that related to anesthesiologists compensation arrangements unless the statement contained and was not inconsistent with the following language:

It is the official policy of the [ASA] that an anesthesiologist is free to choose whatever arrangement he prefers for compensation of his professional services. The Society does not consider the arrangement so chosen to be a matter of professional ethics.

Id. at 105 (emphasis added).

ANTITRUST PROTECTION IN CURRENT ANESTHESIA MARKETPLACE

Current economic practices in the field of anesthesia do not reflect the normal workings of the marketplace. It has been said that they reflect a modern version of mercantilism in which the winners are those who can most effectively influence the rules of the game, not those who can most efficiently produce the goods or services. A successful market competitor competes, increases choices, and lowers prices. On the other hand, a mercantilist monopolizes, restricts choices, and raises prices.

Attempts have been made by some physicians to keep CRNAs from freely competing in the marketplace by creating barriers to practice. Examples of barriers to practice include, but are not limited to, hospital medical staff bylaws which deny CRNAs clinical practice privileges, specific restrictions on clinical practice privileges of CRNAs, promulgation of inaccurate information about a surgeon's liability for CRNAs, and the formation of large anesthesiologist groups. Whether specific barriers to CRNA practice constitute anticompetitive behavior under the antitrust laws obviously depend on the facts of each case. However, CRNAs want to retain the ability to utilize appropriately the current antitrust protections, for example, conspiracies in restraint of trade, conspiracies to price-fix, attempts to monopolize, threats of boycott or actual boycotts, or group refusals to deal.

1. Hospital Medical Staff Bylaws Which Deny CRNAs Clinical Practice Privileges

Some physicians have created hospital medical staff bylaws that effectively eliminate the opportunity for independent CRNA practice. In one such case, the hospital, upon recommendation of a group of anesthesiologists changed its bylaws to state that "nurse anesthetists could only practice in the institution if they were employees of the physician anesthesiologists." This bylaw effectively restricts an independent CRNA from applying for medical staff clinical practice privileges. Without the opportunity to obtain medical staff clinical practice privileges at a hospital, independent CRNAs do not have the ability to administer anesthesia to patients in that facility. Therefore, they would have to become employees of an anesthesiologist group or some other entity in order to provide anesthesia in that hospital. When CRNAs are employees of anesthesiologists, though, the price of their anesthesia service is set by the employer at what would probably be a higher rate than what an independent CRNA would charge for the same service. As a result, the patients at that hospital would lose their competitive choice.

2. Specific Restrictions on Clinical Practice Privileges of CRNAs

While CRNAs do have the right to practice in many institutions, there have been situations where anesthesiologists, through the medical staff structure, have restricted the scope of practice of CRNAs. If their scope of practice is limited, then CRNAs cannot compete with the "full service" anesthesiologists. Restrictions on scope of practice have included: refusal to grant clinical practice privileges for regional anesthesia, insertion of invasive monitoring lines and postoperative pain management of patients. Another example of a practice limitation is when a CRNA is only allowed to monitor an obstetrical patient after an anesthesiologist has administered an epidural injection (a regional anesthetic), even though the CRNA is legally

qualified to actually administer the epidural injection. Other CRNAs experience unnecessary limitations on which types of patients they may treat. These restrictions on clinical practice privileges are not related to education or ability, but rather to the desire by some physicians to control the scope of practice of their competitors.

3. Promulgation of Inaccurate Information about Surgeon's Liability for CRNAs

It is difficult for CRNAs to compete in the market when anesthesiologists use inaccurate information to persuade surgeons not to utilize CRNA services. In one such situation in Southern California, an anesthesiologist sent promotional and marketing letters to plastic surgeons, ophthalmologists and other physicians stating that the surgeons had increased liability if they used a CRNA rather than an anesthesiologist. It is important to understand that typically in cosmetic plastic surgery, the patient pays for the procedures, as insurance does not cover such operations. Plastic surgeons, recognizing the competitive pricing and high quality of care provided by CRNAs, have utilized these practitioners for many years. However, inaccurate information regarding liability of the surgeons for care provided by CRNAs could have had a significant adverse influence on surgeons' use of nurse anesthetists. The California Association of Nurse Anesthetists was able to use the threat of antitrust action to remedy this situation.

4. Formation of Large Anesthesiologist Groups

In recent months, large anesthesiology groups that have taken over anesthesia services in several hospitals, or in all of the hospitals, in certain major metropolitan areas. In those situations where the anesthesiologist group has an exclusive contract that prohibits competitors

from gaining access to the facility, the free market for anesthesia services in those areas is a casualty. Examples of two current situations involving exclusive contracts are provided below.

The first exclusive contract situation exists in Nashville, Tennessee. As of January 1, 1994, there was a merger of two anesthesiologist groups (Middle Tennessee Anesthesiology, P.C. and Anesthesiology Consultants of Nashville, P.C.), which both served metropolitan Nashville, Tennessee and surrounding Davidson County. The new group, called Anesthesia Medical Group, includes 60 of the 111 non-teaching anesthesiologists serving the metropolitan Nashville area. Anesthesia Medical Group employs 105 of the 175 CRNAs practicing in the same area.

In the Nashville area there are 3,906 staffed hospital beds distributed among 12 hospitals. Anesthesia Medical Group is the sole anesthesia provider in two hospitals comprising one third of the available staffed hospital beds in Nashville. In a third hospital, with 571 staffed beds, the group does not have an exclusive arrangement, but provides approximately 65 percent of the anesthesia.

Therefore, Anesthesia Medical Group contains approximately 54 percent of the practicing anesthesiologists, controls 60 percent of the CRNAs in the area, and has exclusive or nonexclusive access to nearly one half of the staffed hospital beds in the area they serve. No other group of anesthesiologists in the area has over 20 anesthesiologist members.

Anesthesia Medical Group because of its size, is well in excess of the September 15, 1993 U.S. Department of Justice FTC Statement of Antitrust Enforcement Policy in the Health Care Area (hereinafter "antitrust guidelines"), which allow a safety zone for physician joint ventures comprised of 20 percent or fewer of the physicians practicing in the relevant geographic

market. This new dominant group of anesthesiologists has used its obvious market power to lower the compensation of the CRNAs employed by one of the two merged anesthesia groups.

The group's size constitutes an effort to improve its bargaining position with hospitals and insurance companies. However, such large concentrations of market power create anticompetitive risks and may constitute a violation of the antitrust laws.

The second potential exclusive contract situation exists in Denison, Texas. Texoma Medical Center, Inc. (TMC), is a not-for-profit corporation which operates a hospital in Denison, Texas. It is estimated that TMC provides medical care and treatment and surgical facilities for approximately 95 percent of the residents of Denison, Texas. TMC has approximately 15 to 20 surgeons on staff and has extended clinical privileges to four anesthesiologists and four CRNAs.

In January 1994, the hospital administrator and CEO of TMC, announced the hospital's intention to enter into an exclusive provider agreement "with a single source for all anesthesia care required by surgeons and patients of TMC." In conjunction with this announcement, he requested that certain physicians submit a proposal to the hospital for an exclusive provider agreement. No request for proposal was made to any of the CRNAs at the hospital with staff privileges, even though the amount charged by CRNAs for anesthesia services is less than the amount charged by anesthesiologists, and only those physicians to whom the request for proposal was submitted were eligible to make a proposal. CRNAs will be allowed to continue providing services at the hospital only if they are employed by the exclusive provider group.

Subsequent to the request for proposal made by TMC, a CRNA with staff privileges at the hospital, obtained a temporary injunction against TMC, prohibiting TMC from interfering with

his staff privileges. This temporary injunction was based upon the fact that TMC's actions were not in compliance with the medical staff bylaws.

At or about the same time, three CRNAs practicing at the hospital and one anesthesiologist practicing at the hospital, communicated their intent to initiate antitrust proceedings against the hospital in the event TMC chose to go forward with its exclusive provider agreement. Upon receipt of that notice, the hospital administrator advised these persons that the hospital was no longer pursuing that course and that the parties would be notified in the event the hospital decided to take actions which would be harmful to them.

AANA OPPOSITION TO WEAKENING EXISTING ANTITRUST LAWS

I. President Clinton's "Health Security Act" Antitrust Exemption Provisions

The AANA opposes the provisions in Section 1322(c) of President Clinton's "Health Security Act" (HR 3600/S 1757), which would grant an antitrust exemption to provider groups to collectively negotiate with regional alliances over fee schedules to be paid under fee-for-service plans. Much of our concern arises because, unlike the present judicial tests for state action and Noer-Pennington immunity, Section 1322(c) fails to provide for any real supervision over provider conduct during the fee-setting and fee-negotiation process. Therefore, members of our association, having less negotiating power than dominant provider groups, risk being ignored or excluded entirely from the negotiation process.

In addition, we are concerned that the Health Security Act specifies that fee schedules are "state regulated". Therefore, concerted refusals by anesthesiologists to deal with CRNAs who may not agree to practice restrictions, would not be actionable under the federal antitrust laws.

For example, a fee schedule between a provider group and an alliance that reflected a policy not to engage CRNAs who did not work for anesthesiologists would not involve a prohibited boycott, since the refusal to deal with independent CRNAs would be the direct result, not a collateral result, of the agreement. If concerted refusals to deal with CRNAs are immunized from antitrust attack, CRNA independent practice is threatened.

2. Hatch/Archer Antitrust Bills (S 1658/HR 3486)

The AANA also opposes the "Health Care Antitrust Improvements Act of 1993" (S 1658/HR 3486), companion bills introduced by Senator Orrin Hatch (R-UT) and Representative Bill Archer (R-TX) respectively. We believe that there is no documented need to expand the "safety zones" created in the September 15, 1993 U.S. Department of Justice/FTC antitrust guidelines.

One reason for our opposition is that the bills would exempt certain activities from the antitrust laws if the conduct falls within a safe harbor defined by the legislation. One of the safe harbors is collective activities related to the provision of health care services in which the number of each type of provider or specialty does not exceed 20 percent. (S 1658 states 20 percent, while HR 3486 states 25 percent).

This creates a statutory antitrust bar in situations where 20 percent of the anesthesiologists in a relevant geographic market come together for the express purpose of engaging in anticompetitive behavior, such as attempts to boycott CRNAs or conspiracies to price-fix. Let's create a hypothetical situation where there are 50 anesthesiologists in a relevant geographic market and five hospitals. If 10 anesthesiologists insisted on an exclusive contract with one hospital and refused to work with CRNAs, they would fall within the 20 percent safe

harbor. If the same 10 anesthesiologists mandated to that one hospital that they would only work with CRNAs who were employed by their anesthesiology group, they would fall within the 20 percent safe harbor. Taking our hypothetical one step further, each of the five hospitals could have 10 anesthesiologists and fall within the 20 percent safe harbor. The 10 anesthesiologists at each hospital would not even have to collude with each other to create an anticompetitive copycat effect. This means that if the 10 anesthesiologists at one hospital decided to collectively negotiate and raise their fees, the 10 anesthesiologists at each of the other four hospitals could take note of that fact and raise their fees to match. This type of copycat effect would increase costs to the consumer.

Another hypothetical involving the 20 percent safe harbor would be a situation where anesthesiologists could act collectively for the express purpose of keeping managed care entities out of a rural area because managed care entities often utilize cost-effective CRNAs to provide anesthesia. In our hypothetical, a small town of 25,000 may have one hospital and one anesthesiologist group, which consists of two anesthesiologists. Taken alone, the two anesthesiologists may comprise 100 percent of the anesthesiologists in that small town and, therefore, would fall outside of the 20 percent safe harbor. However, the more likely definition of the relevant geographic market for the small town would be one that includes the hypothetical city of 100,000 within 15 miles of the small town. That city has three hospitals and 10 anesthesiology groups. Each of the 10 anesthesiology groups consists of two anesthesiologists. There is no anesthesiology group that has more than 20 percent of the relevant market and, therefore, each anesthesiology group has the protection of the 20 percent safe harbor. If the two anesthesiologists at the small town hospital are added to the 20 anesthesiologists at the city hospitals, the two anesthesiologists at the small town hospital may now be eligible for protection under the 20 percent safe harbor. This could empower the two

anesthesiologists at the small town hospital to act collectively to prevent managed care entities, who may rather utilize CRNAs, from moving into their small town.

Currently the U.S. Department of Justice and the FTC have the authority to evaluate whether the conduct in the above hypotheticals fell within the "extraordinary circumstances" exception to the 20 percent safety zone created in the September 15, 1993 U.S. Department of Justice/FTC antitrust guidelines. Under the Hatch/Archer bills, the U.S. Department of Justice and FTC would have no discretion to review these cases because they would fall within a statutory antitrust safe harbor.

A second reason for our opposition to the bills is they create another safe harbor for standard setting and enforcement activities by medical self-regulatory entities, such as the ASA. Standard setting and enforcement activities are defined to include accreditation of practitioners, risk management, practice guidelines, and peer review of medical professionals. These provisions would immunize the ASA Anesthesia Care Team pronouncements from antitrust challenge. The ASA Anesthesia Care Team pronouncements have stated that ideally all anesthesia should be performed by an anesthesiologist, or at minimum by an anesthesia care team (CRNA and anesthesiologist working together). The AANA does not support the ASA Anesthesia Care Team pronouncements because the AANA believes that CRNAs are fully qualified to work alone as private practitioners and should not be restricted to working only as part of an anesthesia care team. CRNAs should have the right to engage in the type of anesthesia practice that they choose.

A third reason for our opposition is that practice guidelines created by the ASA would be immune from antitrust challenge. These practice guidelines could be used to restrict CRNA

practice by, for example, requiring that only anesthesiologists could provide regional anesthesia for obstetrical cases.

CONCLUSION

CRNAs have the education and ability to compete in the health care marketplace due to the cost-effectiveness and quality of the services they deliver. However, based on historical and recent experience in the evolving health care marketplace, CRNAs often do not have a level playing field on which to compete. Even with the protection of the current antitrust laws, some anesthesiologists may successfully restrict the practice of CRNAs or actually exclude CRNAs from hospitals. Without the protection of the current antitrust laws, anesthesiologists may successfully eliminate the practice of their competitors - CRNAs.

The current antitrust laws are intended to preserve competition and promote consumer welfare. Expanding antitrust exemptions beyond what current law permits would only serve to undermine these objectives by eliminating competition, limiting consumer choice, and increasing costs to consumers. Therefore, the American Association of Nurse Anesthetists strongly opposes any weakening of the current antitrust laws.

Thank you for your consideration of our views.

Mr. BROOKS. Thank you very much.

Having traveled with those anesthesia people, when you are going to go under, you want to be very, very careful of who they are, regardless of what they call themselves. If there is any overkill, it is fatal. It doesn't make any difference what the doctor does to you after you are under. If you don't come back, it doesn't make any difference. You have got to be very careful about them. I analyzed them pretty close. Did a good study on them before I decided to take that trip.

Next, we have Mr. Alphonso O'Neil-White, the vice president and general counsel for Group Health Association of America. His group is the Nation's largest trade association representing health maintenance organizations. We are delighted to have you here.

STATEMENT OF ALPHONSO O'NEIL-WHITE, VICE PRESIDENT AND GENERAL COUNSEL, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Mr. O'NEIL-WHITE. Thank you, Mr. Chairman. As you mentioned, GHAA is the national association of HMO's. We represent 360 HMO's nationwide. They provide health care to 35 million Americans.

The HMO's GHAA represents range from the 3,500-member Heart of America Plan in Rugby, ND, to the 6.6 million-member Kaiser Foundation Health Plan based in Oakland, CA. These include physician-owned and controlled plans, hospital/physician-owned and controlled plans, and consumer-controlled cooperatives.

Today, roughly one out of every five Americans who has health insurance is enrolled in an HMO. GHAA estimates that HMO enrollment will exceed 50 million by the end of 1994.

On behalf of our member companies and their enrollees, we appreciate the opportunity to speak to you today, Mr. Chairman. Today we will discuss issues of utmost importance to health care consumers like you and me, of importance to the industry, and to the future of health care reform.

The issue is whether there is a demonstrated need to fundamentally change the current antitrust laws. The basic purpose of antitrust laws and antitrust enforcement in the health care industry is to promote and preserve competition, not to protect individual competitors or to provide shelter for special interest groups.

The antitrust laws are neutral in this respect. They do not discriminate against any group of sellers or buyers, but apply equally to everyone. Competition promotes consumer choice, cost containment, and innovative approaches to health care delivery that benefit consumers. These are the specific goals of health care reform.

No amount of structural reform in the health care industry, however, will succeed if providers are organized into tightly knit cartels that reduce output, lower quality, increase prices, stifle innovation, or restrict entry to communities. Vigorous and sound antitrust enforcement is the best mechanism for preventing price fixing, boycotts, and anticompetitive mergers or joint ventures that inevitably lead to higher prices for consumers or exclude competitors from a dynamic and rapidly changing marketplace.

Thus, antitrust enforcement is essential to achieve many of the fundamental goals of health care reform. Today's health care marketplace demonstrates that existing antitrust laws promote pro-competitive collaboration by providers.

The fact is the existing antitrust laws have benefited health care consumers by removing obstacles to the formation and expansion of HMO's as an alternative to fee-for-service medicine. In fact, they have also facilitated physician controlled networks and other integrated delivery systems.

Based on a GHAA survey, almost 4 million Americans receive care through HMO's that are owned and controlled by either physicians, physician hospital ventures, or hospitals. If you also include HMO's that have significant physician involvement in their operations, that enrollment jumps to over 10 million.

Unfortunately, legislation being proposed for consideration by the Congress would protect some types of anticompetitive activity that would directly threaten the viability of HMO's and other alternatives for fee-for-service medicine. This includes section 1322(c) of the Health Security Act as well as proposals in House bill 3486 and Senate bill 1658.

GHAA opposes any policy or legislation that would protect such anticompetitive activity. Some of the proposals would create broad antitrust exemptions that go far beyond exceeding antitrust law without any empirical data to justify the need for sanctioning such activities.

In fact, the legislation would likely undermine the consumer protections the current antitrust laws are intended to provide, protections that have also enabled integrated health care delivery systems to flourish while retaining fee-for-service medicine as a real and effective option.

And at least one proposed exemption for physician networks would effectively overrule 75 years of Supreme Court precedent declaring collective negotiations by unintegrated competitors to be illegal. There is no reason to believe that this kind of activity will lead to lower prices for consumers in a reformed environment.

Antitrust enforcement has played a significant role in keeping markets open to HMO's by stopping conspiracies to boycott or fix prices or by preventing the unlawful use of market power by provider groups to exclude HMO's and managed care plans from the health care markets. We expect antitrust enforcement to continue to play a critical role as HMO's enter new communities.

This will be particularly critical in small-town America where HMO's face many difficult challenges, because rural Americans often live far away from providers and major medical centers. HMO providers, however, have treated the challenges in rural America as opportunities rather than obstacles. Examples abound that demonstrate a number of innovations in rural health care delivery systems have been implemented successfully within the framework of current antitrust laws.

We urge this committee to consider the essential role that the antitrust laws have played in the historical development of managed care as a viable alternative to fee-for-service medicine and to

recognize that the future of similar innovations in health care delivery in urban and rural America will depend in large part on the continued role of sound, vigorous antitrust enforcement.

GHAA wishes to thank the committee and the chairman for this opportunity to express its views on this very important issue. We reaffirm our commitment to work with this committee and other Members of Congress as the health care reform debate proceeds.

Mr. Chairman, we ask that our written statement be submitted for the record.

Mr. BROOKS. Without objection, so ordered.

[The prepared statement of Mr. O'Neil-White follows:]

STATEMENT OF ALPHONSO O'NEIL-WHITE, VICE PRESIDENT AND GENERAL COUNSEL, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Good morning Mr. Chairman and Members of the Committee. My name is Alphonso O'Neil-White, and I am the Vice President and General Counsel of Group Health Association of America (GHAA). GHAA is the national association of health maintenance organizations (HMOs) that represents 360 HMOs and whose members account for about 80 percent of total HMO enrollment nationwide. On behalf of our members and their enrollees, we appreciate your invitation to testify today.

COMPETITION IS CRITICAL TO HEALTH CARE REFORM

The HMO industry has been on the cutting edge of health care reform for more than 50 years. HMOs and other managed care plans offer comprehensive services to enrolled members on a prepaid, rather than on a fee-for-service, basis.

HMOs are health care systems that deliver that care through highly qualified health care professionals. Their primary goals are keeping their members well and providing first rate health care. Consumers consistently give HMOs positive reviews, which are reflected in high enrollment renewal rates. In fact, HMO enrollment has quadrupled during the past decade alone based almost entirely on consumer choice. Today, roughly one out of every five Americans who have health insurance are enrolled in HMOs, and GHAA estimates that HMO enrollment will exceed 50 million people by the end of 1994. The vast majority of these HMO members selected their plans in an environment of choice — they chose to be our members. (See Attachment A)

HMOs organize the delivery of comprehensive health care services in a way that makes a great deal of sense to many Americans. The benefit packages we offer tend to be significantly broader and more complete than those offered by indemnity insurers. Out-of-pocket costs are invariably lower. The collective experience of the managed care industry is a substantial part of the blueprint for many of the health care reform bills currently under consideration in Congress.

The topic of this hearing today is important to consumers, our industry, and to the future of health care reform. The basic purpose of the antitrust laws and antitrust enforcement in the health care industry is to promote and preserve competition for the benefit of consumers, not individual competitors. The antitrust laws are neutral in this respect. They do not favor or discriminate against any group of sellers or buyers; they apply equally to everyone. The antitrust laws and antitrust enforcement have played an historic and special role in the development of managed care as an alternative to fee-for-service medicine for consumers. We agree with Assistant Attorney General Bingaman's statement in her recent letter to Chairman Brooks that some of the proposed legislative provisions we are discussing here may protect anticompetitive conduct that significantly harms consumers.¹

Antitrust enforcement was directly responsible for enabling the first HMO-type plan to form more than 50 years ago. In 1941, the Supreme Court upheld a criminal antitrust conviction of the American Medical Association and the Medical Society of the District of Columbia for conspiring to obstruct the operation of Group Health Association, an early HMO-type plan here in Washington, D.C.² In that case, the associations initiated disciplinary actions against Group Health Association staff physicians, imposed sanctions against doctors who consulted with Group

Health Association physicians, and took various actions against hospitals that granted privileges to Group Health Association doctors — all in an effort to prevent GHA from providing an alternative to fee-for-service practice. Unfortunately, a great deal of similar activity still occurs today.³

Antitrust laws continue to benefit health care consumers by removing obstacles to the formation and expansion of HMOs as alternatives to fee-for-service medicine. For example, challenges have been brought against professional society ethical rules and "self-regulation" that prohibited contracting with managed care plans,⁴ denials of hospital privileges to doctors affiliated with HMOs,⁵ restraints by dominant fee-for-service payors on physicians affiliating with HMOs,⁶ and combinations among providers to force higher reimbursements.⁷ The enforcement agencies have also challenged conspiracies to obstruct utilization review programs,⁸ and boycotts and other conspiracies to maintain prices or force increases in reimbursements.⁹

Competition has enabled managed care plans and other new forms of health care delivery systems to provide all consumers with high-quality care through alternatives to traditional fee-for-service practice. Competition between health plans, for instance, has encouraged innovation, enhanced quality, and increased efficiency in health care delivery. Similarly, greater use of selective contracting and competitive bidding has generated efficiencies and improved quality, as providers have vied to demonstrate the value and dependability of their services.

Today's health care marketplace demonstrates that existing antitrust laws promote procompetitive collaboration by providers. For example, a recently released study of the American Medical Association reports that 33 percent of physicians are involved in medical group practices, compared with 18 percent in the 1960s.¹⁰ Joint ventures among hospitals to purchase, operate or market high-technology medical equipment have never been challenged by federal enforcement agencies. Nor have the agencies challenged joint purchasing arrangements among hospitals for services such as laundry and data processing.

In addition, most hospital mergers are procompetitive or competitively neutral, a fact demonstrated by the very few challenges to the hundreds of hospital mergers that have occurred over the past decade. The Department of Health and Human Services reached the same conclusion after a three year study to determine if the antitrust laws were "chilling" hospital mergers. The study concluded that (1) there was no empirical evidence to support this assertion; (2) the enforcement agencies had made and are continuing to make a significant effort to educate the health care industry about their enforcement policies; (3) antitrust enforcement policies do not conflict with HHS's policies; and (4) it is not necessary or appropriate on the basis of current enforcement policies to support legislation that would exempt hospital mergers from scrutiny under the antitrust laws.¹¹

No amount of structural reform in the health care industry will succeed if providers are organized into tightly knit cartels that reduce output, increase prices, stifle innovation or restrict entry. Sound antitrust enforcement is the best mechanism for preventing price fixing, boycotts, market allocation schemes and anticompetitive mergers or joint ventures that can lead to higher

prices for consumers or exclude competitors from a dynamic and rapidly changing marketplace. Thus, antitrust enforcement is essential to achieve many of the fundamental goals of health care reform.

Unfortunately, legislation being considered by Congress would protect some of these types of anticompetitive activity and threaten the viability of HMOs and other alternatives to fee-for-service medicine. GHAA is particularly troubled by legislative proposals that create broad antitrust exemptions that go well beyond existing antitrust law. The wholesale exemptions they establish are completely unjustified.

SOUND ANTITRUST ENFORCEMENT WILL HELP RURAL AMERICANS

Antitrust enforcement has played a significant role in keeping markets open to HMOs by stopping conspiracies to boycott or fix prices, or by preventing the unlawful use of market power by provider groups to exclude HMOs from health care markets. We expect antitrust enforcement to continue to play a critical role as HMOs enter new communities. This will be particularly true in rural settings, where HMOs face many difficult challenges because rural Americans often live far away from providers and major medical centers. Rural populations are generally older and have lower incomes than their urban counterparts; their demand for medical services is high while access to providers is more limited.

HMO providers, however, have treated the challenges in rural America as opportunities rather than obstacles. In 1990, 301 HMOs served both urban and rural counties and 15 more served only rural counties. Some HMOs are expanding into these areas by using a "hub and spoke" approach, establishing their own clinics or contracting with independent physicians and hospitals in small communities so that members can obtain primary and secondary care from local providers. Specialized care and a wider range of physicians and therapists are available in the "hub" location. Other established HMOs have provided the start-up capital to finance new clinics, and have recruited providers to staff the clinics. Often, HMOs contract with visiting specialists or use staff from other facilities to provide back-up services for local physicians. Some examples of HMOs that successfully serve rural areas include:

"Heart of America" HMO in Rugby, North Dakota is in an area surrounded by farms of 6,000 to 8,000 acres where many families live miles away from their nearest neighbors. The region's reliance on farming, ranching and small business is reflected in the fact that almost half of Heart of America's 3,500 members enroll as individuals. Heart of America provides health services through a contract with Rugby's Johnson Clinic, a facility that operates four satellite clinics throughout the area. To meet the health care needs of its members without hiring excess staff, the HMO uses a wide array of medical providers: physician assistants offer many primary care services; internists and a surgeon serve on staff; University of North Dakota medical students do rotations at the facility; and Heart of America contracts with specialists on a part-time basis.

"Community Health Plan" (CHP) is based in Albany, New York, but 26 percent of its 325,000 members live in rural areas of New York, Vermont and Massachusetts. Because of its strength in urban and suburban areas, CHP has adequate capital and other resources to support expansion into underserved rural areas. It often moves into a community at the request of local residents, contracting with local physicians or bringing them onto CHP's staff. CHP was invited to Hoosick Falls, for example, when the town's only physician began thinking about retirement. In addition to that doctor, who continues to practice, Hoosick Falls now has a CHP health center staffed with the equivalent of 3 1/2 physicians and a physician's assistant.

"Scott and White Health Plan" ("the Plan") is a group model HMO serving 100,000 members in 20 central Texas counties. A nonprofit, physician-controlled HMO, the Plan provides health care to many rural communities within a 90 mile radius of Temple, Texas. Thirteen satellite clinics provide primary care to the Plan's members living in communities with as few as 25 residents. The Scott and White organization also includes the 350-bed Scott and White Memorial Hospital and 450 salaried physicians of the Scott and White Clinic. This structure allows the Plan's members to obtain most medical services close to home, while ensuring them access to larger medical centers when they need more specialized or higher technology care.

"Lovelace Health Systems" is based in Albuquerque, New Mexico but it is expanding into rural areas of the state. This 142,000 member HMO has established a 24-hour, toll-free "hotline" that is available statewide. Each day about 200 callers speak with registered nurses who provide health care advice, information about community services, and direct tie-ins to state police and emergency response services. All Lovelace providers are linked by a common data base that makes patient information available at all sites, and on-line transmission of electrocardiograms and X-rays enables specialists to interpret test results for rural primary care physicians. Lovelace also has a rural "immunization van," a cooperative project of the HMO, the state health department, and New Mexico's First Lady. The van visits schools and churches in more than 20 small communities to provide immunizations in areas where there are no health care facilities.

"Healthsource Maine", a federally qualified HMO owned and operated by Healthsource, Inc., is based in Freeport, Maine. Healthsource Maine enrolls 53,500 members and serves the entire state of Maine. From 1988-1993, Healthsource Maine was involved in an alliance with the Robert Wood Johnson Foundation and the State of Maine in the MaineCare Demonstration Project, a public/private collaborative model to extend health insurance coverage to uninsured small businesses and the self employed in rural Maine. Sponsored and administered by the Department of Health Services, MaineCare was a successful four-year pilot program offering comprehensive coverage through a contractual arrangement with Healthsource Maine. Through a combination of premium subsidies, careful benefit design, active utilization review and sophisticated pricing arrangements with providers, MaineCare succeeded in providing high-quality care and containing health

care costs. MaineCare appealed to the targeted population through cooperation of employees, employers, hospitals, physicians and the state government.

These and many other innovations in rural health care delivery have been implemented within the framework of current antitrust laws. In other words, cost-effective, efficient and procompetitive arrangements are occurring.

GHAA recognizes the health care needs of rural America for new services delivery systems, new providers, and new investment. You will note, however, that for these efforts to be successful, it is necessary to bring together many types of non-physician providers. Collusion by competitors works to freeze in place the status quo and often prevents new entrants into the market — an outcome no one desires.

For example, over the past decades, there have been many efforts by provider groups to prevent non-allied providers such as nurse-midwives from participating in various health care delivery systems. Rural communities need both to expand their current effective utilization of non-physician providers, and to attract and retain greater numbers of physicians.

Sound antitrust enforcement has broken down many of these barriers. The future success of these efforts, however, will be undermined if anticompetitive activities among health care providers are allowed to obstruct the ability of HMOs and other managed care plans to contract selectively with providers, or to hinder plans' cost containment efforts and quality assurance objectives.

HEALTH CARE POLICY STATEMENTS

In the past, GHAA has supported the enforcement agencies' efforts to clarify their enforcement policies and intentions. This need for knowledge and greater understanding has been particularly important for our rural members who often cannot achieve efficiencies that their urban counterparts enjoy without mergers or joint ventures, but may be uncertain about activities that are permissible under current law. Thus, we were pleased when the Department of Justice and Federal Trade Commission jointly announced antitrust Health Care Policy Statements last September,¹² which, along with their many public speeches and statements, have given our members and, we believe, all providers, a clearer understanding of current enforcement policies and the kinds of activities they can safely undertake.¹³

From our perspective, the Policy Statements are unusual for at least three reasons. First, they are industry specific, offering health care providers guidance tailored to their unique circumstances and concerns. Second, they create "safety zones" that assure providers that they will not be prosecuted for a wide range of activities, absent "extraordinary circumstances." This is particularly beneficial to rural providers who might otherwise be hesitant to engage in joint ventures that produce efficiencies or new services because of their uncertainty about the antitrust laws. For example, the hospital merger safety zone is specifically targeted to small, rural

hospitals that are unlikely to achieve the cost-saving efficiencies that larger hospitals enjoy without merging.

Third, the Policy Statements for the first time commit the enforcement agencies to respond to requests from the health care community for business reviews or advisory opinions on prospective transactions in 90 days regarding any matter addressed in the Policy Statements, except requests relating to hospital mergers that are outside the safety zones. Thus, even if providers remain uncertain about whether their proposed activities fall within the safety zones, they are guaranteed an answer from the agencies in less than three months.¹⁴

These Policy Statements are also important for another reason. They not only help remove enforcement uncertainty, but they have opened an important dialogue with the industry that must continue. This dialogue and the enforcement agencies' commitment to issue additional policy statements when needed will enhance the responsiveness of all concerned to the realities of a changing marketplace.

LEGISLATIVE EXEMPTIONS

GHAA opposes any policy or legislation that would make it harder to challenge anticompetitive combinations or agreements among local health care providers, whether organized informally or through cartels, joint ventures, networks, associations or mergers. If H.R. 3486, and similar provisions in S. 1658 and S. 1770, are enacted, the ability of enforcement agencies to be responsive and flexible will be seriously threatened. These bills raise precisely these possibilities; they would create broad antitrust exemptions that go far beyond existing antitrust law without any empirical data to justify the need for sanctioning such potentially anticompetitive activities. In fact, the legislation would likely undermine the consumer protections the current antitrust laws are intended to provide protections that have also enabled integrated health care delivery systems to flourish as innovative, cost-effective alternatives to fee-for-service medicine.

In short, GHAA opposes any legislation of this type because (a) the antitrust laws have not impeded procompetitive mergers or joint ventures; (b) the legislative provisions would sanction anticompetitive activities; (c) statutory exemptions are inflexible and unresponsive to changes in a rapidly changing health care marketplace; and (d) some exemptions would require expensive, regulatory bureaucracies to implement them. The Health Care Policy Statements issued by the enforcement agencies do not have these problems. Our analysis of the legislative provisions in H.R. 3486, S. 1658 and S. 1770 ("the legislation") illustrates these concerns.¹⁵

PHYSICIAN NETWORK IMMUNITY WOULD INCLUDE ALL PROVIDERS

H.R. 3486 would exempt physician networks of 25 percent or less of the physicians in each specialty who practice in various geographical markets, and extends this immunity to all providers.¹⁶ Significantly, the Policy Statement on physician networks limits the size of these networks to 20 percent of the physicians in each specialty in a geographic market and require

joint venture participants to share substantial financial risk of profit and loss. The safe harbor in the proposed legislation, however, would cover much more than joint ventures. It would effectively immunize price fixing among competing providers based solely on their market share without any consideration of whether the joint venture has a procompetitive purpose, would raise prices above competitive levels or prevent the formation of other joint ventures.¹⁷ The safe harbor in the proposed legislation would also have the effect of overruling 75 years of Supreme Court precedent which has declared such activity by unintegrated competitors to be per se illegal.¹⁸

The harm to consumers and managed care plans from such an exemption cannot be underestimated. In short, it is a license for 25 percent of the competitors in a market to fix prices, boycott or divide the market. Such illegal joint ventures would become common where they involved less than 25 percent of the market, and would directly impede the ability of managed care plans to contain costs and enter new markets. One could envision the possibility of four cartels existing in a market to negotiate with HMOs and other payers. The impact from such anticompetitive activities would be exacerbated in small communities. HMOs would have great difficulty contracting with providers without facing boycott threats or price-fixing conspiracies. The legislation appears to respond to the perception among doctors that they cannot compete on an equal footing with insurance companies under the antitrust laws. There is no question, however, that physicians can establish and operate plans that are directly competitive with insurance companies and, in fact, are doing so.¹⁹ In short, there is no reason to believe or evidence to support the claim that allowing competing providers to collectively bargain or negotiate with purchasers leads to lower costs and better services for consumers.²⁰

IMMUNITY FOR "GOOD FAITH" SELF-REGULATION

The legislation permits "good-faith" standard setting and enforcement by any medical self-regulatory entities, such as hospital boards and medical societies, unless such activities are done for "financial gain."²¹ In contrast, the Policy Statement on this subject allows only physicians to collaborate to provide data to third-party payers and set practice parameters, and specifically exclude boycott threats and fee-related information from the safety zone. The history of the health care industry is replete with examples of boycott threats by physicians who, in the guise of "standard setting" or "quality control," have attempted to coerce managed care plans into meeting their demands. When physicians and other providers have the unrestrained authority to dictate standards and engage in enforcement (disciplinary) activities, the possibility of anticompetitive behavior increases substantially and innovative modes of practice such as HMOs and other models of managed care can be suppressed. Some hospitals have used the peer review process to deny privileges to competing practitioners where the denial was unrelated to quality of care issues. Thus, the failure of the proposed legislation to prohibit these practices significantly expands the Policy Statement's safety zone (as well as existing law), undermining the ability of managed care providers to implement cost-saving practices.

IMMUNITY FOR SHARING PRICE INFORMATION

Both the proposed legislation²² and the Policy Statement on information exchanges would exempt participation in third-party surveys on prices and employee compensation if the data is at least three months old and the results are aggregated before dissemination to shield the identity of any particular survey participant. These aggregation and age requirements standing alone are inadequate to prevent signaling or other attempts to fix prices; therefore, the safety zone in the Policy Statement has additional safeguards. It includes only hospitals, rather than all providers. In addition, at least five hospitals must participate, and no single hospital can contribute more than 25 percent of the data. This removes the possibility of two party surveys that would reveal the other party's data, or very small samples in which the identity of the survey participants could easily be determined. These precautions are especially important to the formation of new HMOs and the expansion of existing managed care plans that depend on competition among provider groups to negotiate prices. Under the proposed legislation, with fewer safeguards and no limitations on the providers that can participate, there would be a significantly greater risk that the surveys would be used by providers to exchange current and future price and cost information, activity that has substantial potential for raising health care costs.

IMMUNITY FOR HIGH-TECHNOLOGY JOINT VENTURES AND EXPENSIVE SERVICES

The proposed legislation would significantly expand the protection accorded these types of joint ventures to all providers without any evidence that such broad protection is needed or justified.²³ This is particularly true in light of the enforcement record in this area where there have been no challenges to such joint ventures among hospitals. The Policy Statement on this subject includes a safety zone for high-technology joint ventures that should encourage such undertakings.

The proposed legislation also permits joint ventures for the provision of costly services in addition to equipment, but the services intended to be exempt from antitrust enforcement are undefined. This expansion is not only vague, but there is no evidence that the development of innovative or costly medical services has been impeded by the antitrust laws.

HOSPITAL MERGERS

The proposed legislation permits mergers of hospitals with fewer than 150 operational beds²⁴ while the Policy Statement on hospital mergers places the limit at 100 licensed beds. In addition, the inpatient census under the legislation must be less than 50 percent, while the Policy Statement requires an average inpatient census of less than 40 percent over the three previous years. An expressed intent of the Policy Statement is to permit mergers among small, rural hospitals where demonstrable efficiencies can be realized that otherwise would be impossible. For example, if one of two rural hospitals is failing or they both have a very low patient census, cost savings from consolidating in-patient medical services in one facility and out-

patient services in the other would eliminate wasteful duplication and inefficiency, and would benefit consumers.

The proposed legislation, on the other hand, substantially broadens the class of transactions covered by the exemption. The legislation would cover far more than the special problems of rural, inefficient and economically strapped facilities. The use of operational rather than licensed beds and higher census rates allowed under the **proposed legislation would significantly expand the safety zone in the Policy Statement to exempt hospitals that could be viable without merging.** The effect of the proposed legislation would be to move toward a general exemption for hospital mergers without requiring any empirical evidence that such an exemption is justified.

IMMUNITY FOR "GOOD FAITH" NEGOTIATIONS

The proposed legislation would protect "good faith" negotiations to organize or carry out any of the activities in the safety zones, even if the negotiations are unsuccessful.²⁵ The Policy Statements have no corresponding exemption, for good reasons. First, there is no evidence that such an exemption is needed. Parties have been able to form legitimate, procompetitive joint ventures without this provision. In addition, it raises the serious likelihood of sanctioning sham negotiations that are characterized as unsuccessful efforts to establish legitimate joint ventures, but in fact are little more than collusion to set prices or divide markets. The potential negative impact on managed care is evident. The proposed legislation contains no notification requirements, so the ability of the enforcement agencies to monitor such "negotiations" would be severely inhibited. Thus, parties either could engage in "negotiations" privately, or, if questioned by the enforcement agencies, rely on the "good faith" safe harbor to protect themselves from scrutiny or investigation. The effect would be to create an exemption that encourages collusion.

ADDITIONAL SAFE HARBORS MANDATED

The proposed legislation requires the Attorney General to solicit public proposals for additional safe harbors, determine whether they meet the criteria specified in the bill, and explain her decisions to Congress - all within 180 days of enactment.²⁶ Within the following 180 days - merely one year after enactment - the proposed legislation states that the Attorney General "shall" promulgate additional safe harbors. If additional safe harbors are justified in the health care industry on the basis of experience and economic analysis, however, the enforcement agencies already have the discretion they need to issue **additional Policy Statements or to amend the current Policy Statements to meet the legitimate needs of providers and consumers.** In fact, the Assistant Attorney General of the Antitrust Division has made a public commitment to provide additional guidance based on discussions with various representatives from the health care community.²⁷ This approach is far more flexible and responsive to providers' and consumers' needs than inflexible statutory exemptions that may be overtaken by a rapidly changing health care market.

REQUIRED CERTIFICATION OF COMPLEX TRANSACTIONS

The proposed legislation would confer antitrust immunity on providers who obtain a certificate of review from the Attorney General.²⁸ A certificate would have to be granted if the proposed activities meet the criteria specified in the legislation and the benefits of the venture outweigh its disadvantages. If the Attorney General does not make a determination within 90 days following receipt of an application, it would be deemed to be approved. This "negative option scheme" would overburden the Department of Justice with an expensive, bureaucratic process that would divert its limited enforcement resources. As a result, the Attorney General could be forced to certify complex transactions and activities without adequate consideration of their economic effects to the detriment of managed care plans and consumers. Further, large, highly complex hospital mergers or other transactions that generally take more than 90 days to evaluate could effectively become immune from antitrust scrutiny because the analysis for such large transactions would be impossible to complete under the unduly restrictive time constraints.

ELIMINATION OF PRIVATE ANTITRUST ACTIONS

Under the proposed legislation, joint ventures that are disclosed to the Attorney General would be subject only to Rule of Reason analysis and actual, rather than treble, damages if their activities are later challenged.²⁹ In addition, the losing party in a civil action would bear both the cost of the suit and attorneys fees. This special treatment is extended to provider joint ventures that file no notification at all if their members share substantial financial risk and limit the proportion of providers, or of the specialists in the relevant market, to 50 percent for nonexclusive and 35 percent for exclusive arrangements.³⁰

While not creating an outright exemption, this "special treatment" provision effectively immunizes the health care industry from private antitrust actions. By raising the standard of proof (which is accomplished by shielding conduct such as price fixing from any possibility of per se condemnation), limiting available damages, and shifting costs and attorneys fees to the losing party, significant barriers to bringing a private cause of action are created. HMOs and other entities representing consumers' interests (which are the most likely to be victims of anticompetitive conduct) would be severely inhibited from exercising their rights under Section 4 of the Clayton Act³¹ to pursue civil actions as "private attorneys general" to redress antitrust violations, which Congress originally intended. This is exacerbated by the non-notification provisions which would enable joint ventures to qualify for special treatment without the advance knowledge of the enforcement agencies. This "special treatment" will reduce the ability of managed care plans to protect consumers and to prevent provider joint ventures from engaging in illegal boycott threats, price fixing, and other anticompetitive practices when negotiating with providers.

FEE SCHEDULE NEGOTIATION

GHAA also opposes provisions such as those in H.R. 3600 / S. 1757 (the Health Security Act) that would permit competing providers to collectively negotiate fee-for-service fee schedules with health alliances.³² This legislation would confer antitrust immunity on providers who collectively negotiate a fee-for-service schedule with an alliance even if they are not part of an integrated joint venture.

Although the immunity does not apply to negotiations with health plans or networks, the proposed immunity could have important anticompetitive implications. First, virtually no other group of competing sellers can freely operate as a cartel under similar circumstances. Second, the natural effect of this legalized collusion will be a rise in fee-for-service prices with subsequent increased costs to consumers for whom HMOs or PPOs are not adequate alternatives. Third, but perhaps most important, the collusive activity sanctioned in the newly regulated fee-for-service market poses a significant threat of spilling over into providers' negotiations with other plans, thereby increasing providers' prices to those plans and to all consumers.

CONCLUSION

Vigorous enforcement of antitrust laws is crucial to preserve and ensure competition in the health care marketplace. Competition promotes cost containment, consumer choice and the expansion of managed care and other innovative approaches to health care delivery that benefit consumers. There is no substantive reason why competition cannot continue to serve that role in a reformed health care system. Competition has always encouraged innovation, which is at the heart of health care reform. The antitrust laws are uniquely suited to promote these goals while preventing newly created organizations from being exploited as vehicles for collusive or exclusionary activity that is harmful to consumers.

The proposed antitrust legislation, on the other hand, undercuts the protections of current law and enforcement policies without any empirical evidence to demonstrate that they have chilled or prevented procompetitive collaborations.

Finally, we urge this Committee to consider the essential role of the antitrust laws in the history of managed care, and to recognize that the future of similar innovations in health care delivery in urban and rural America will depend, in part, on the continued role of antitrust enforcement.

GHAA wishes to thank the Chairman and the Committee for this opportunity to present its views.

* * * *

1. See, Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, United States Department of Justice, to the Honorable Jack Brooks, Chairman, Committee on the Judiciary, U. S. House of Representatives (Apr. 14, 1994).
2. American Medical Association v. United States, 317 U.S. 519 (1943) .
3. See United States v. Alston et al., 974 F.2d 1206 (9th Cir. 1992); (price fixing conspiracy by dentists, including the submission of identical letters to managed care plans demanding higher fees (held per se illegal)); United States v. Massachusetts Allergy Society, 19920, Trade Cases (CCH) ¶ 69, 846 (D. Mass. 1992) (conspiracy by allergists to develop a fee schedule and to jointly negotiate with HMOs to obtain higher fees (consent decree)); United States v. Greater Bridgeport IPA, Civil Action No. 592 CU00575 (D. Conn. 1992) (boycott and refusal to deal with an HMO by an IPA and its member physicians to force the HMO to increase the fees it paid to the IPA (consent decree)).
4. American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided court, 455 U.S. 676 (1982); American Medical Association v. United States, 317 U.S. 519 (1943); American Society of Anesthesiologists, 93 F.T.C. 101 (1979).
5. See Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979); Medical Staff of Doctors' Hospital, 110 F.T.C. 476 (1988). See also Medical Staff of Holy Cross Hospital, No. C-3345 (consent order, Sept. 10, 1991); Medical Staff of Broward General Medical Center, No. C-3344 (consent order, Sept. 10, 1991).
6. Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976); Blue Cross of Washington and Alaska v. Kitsap Physicians Service, 1982-1 Trade Cas. (CCH) ¶ 64,950 (W.D. Wash. 1981).
7. Association of Independent Dentists, 100 F.T.C. 518 (1982); Michigan State Medical Society, 101 F.T.C. 191 (1983); United States v. Massachusetts Allergy Society, 1992-1 Trade Cas. (CCH) ¶ 69,846 (E.D. Mass. 1992); United States v. Alston, 974 F.2d 1206 (9th Cir. 1992).
8. See Indiana Federation of Dentists v. FTC, 476 U.S. 447 (1986).
9. See, e.g., American Medical International, 104 F.T.C. 177 (1984); Hospital Corporation of America, 106 F.T.C. 455 (1985), aff'd, 807 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).
10. "Physicians in Medical Groups: A Comparative Analysis - 1993", American Medical Association (1993).
11. "Report of the Secretary's Task Force on Hospital Mergers," Department of Health and Human Services (Jan. 1993).

12. "Statements of Antitrust Enforcement Policy in The Health Care Area", U.S. Department of Justice and the Federal Trade Commission (Sept. 15, 1993).

13. See, Statement of Anne K. Bingaman, Assistant Attorney General, Antitrust Division, United States Department of Justice, before the Finance Committee, United States Senate (May 12, 1994) ("Our goal is to provide antitrust guidance to health care providers themselves, and not only to the antitrust bar that advises the industry.")

14. Since the Policy Statements were issued last September, the Department of Justice has issued nine business review letters dealing with a wide array of proposed transactions. Three proposals involved the formation of provider networks; two involved the formation of groups purchasing health services; one involved a survey of hospital wages; two involved data exchanges; and one involved a request to set maximum prices. Except for the last proposal, all of the business review letters approved the proposed transactions.

15. The Department of Justice has stated that it opposes the statutory immunities that would be created by the legislation. See, Letter from Anne K. Bingaman, supra n. 1. See also, Letter from Paul Beaulieu, Acting Executive Director, National Association of Attorneys General to Honorable Daniel Patrick Moynihan, Chairman, Senate Finance Committee (May 11, 1994) (opposing S. 1658 on behalf of all state Attorneys General because it would impair the goals of health care reform, create special exemptions for the health care industry, and preempt enforcement of state antitrust laws).

16. H.R. 3486, 103rd Cong., 1st Sess. § 3 (1); S. 1770, 103rd Cong., 1st Sess. § 4202(l); S. 1658, 103rd Cong., 1st Sess. § 3(1).

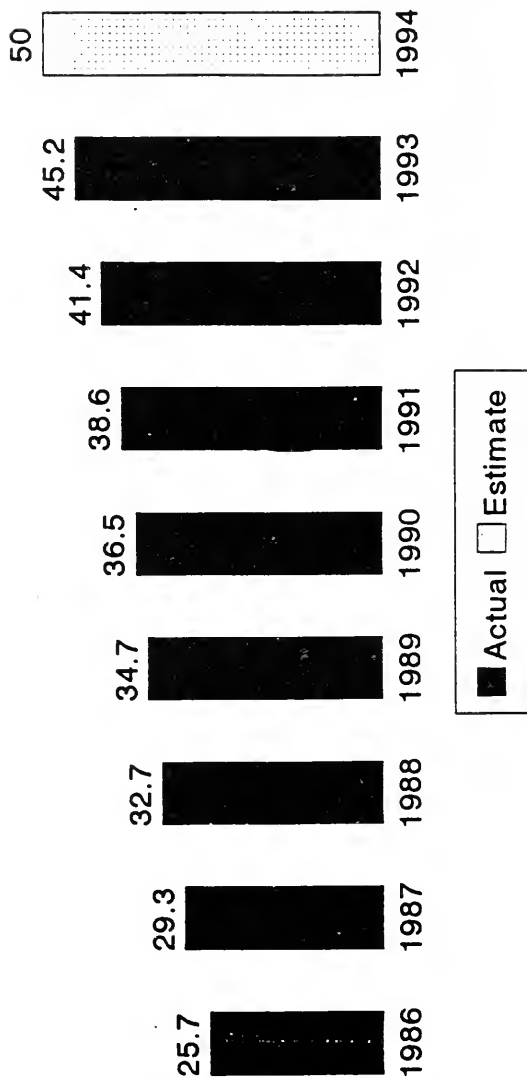
17. The legislation presumes that antitrust violations cannot occur without market power. However, the Second Circuit Court of Appeals recently noted that "[T]he precise role that market power plays in rule of reason analysis of horizontal combinations in conspiracies is a matter of some dispute. . . . The Supreme Court has never explicitly endorsed such a preclusive threshold approach. . . . Nor have we embraced the view that market power is the *sine qua non* of antitrust liability." Capital Imaging v. Mohawk Valley Medical Assoc., 996 F.2d 537, 546 (2nd Cir. 1993).

18. See United States v. Trenton Potteries Co., 273 U.S. 392 (1927)(holding that price fixing agreements are illegal per se under the Sherman Act); United States v. Socony-Vacuum Oil Co., Inc., 310 U.S. 150 (1940)(reaffirming Trenton Potteries and holding that the Sherman Act "establishes one uniform rule applicable to all industries alike"); Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982)(holding that the per se rule applies to price fixing agreements among physicians).

19. See, Letter from Mary Lou Steptoe, Acting Director, Bureau of Competition, Federal Trade Commission, to the Honorable Daniel Patrick Moynihan, Chairman, Committee on Finance, U.S. Senate (May 24, 1994); See also, industry survey of HMOs by Group Health Association of America that showed at least 20 HMOs were physician-owned (Dec. 1992).

20. Id., Letter from Steptoe to Moynihan.
21. H.R. 3486 § 3(2); S. 1770 § 4202(2); S. 1658 § 3(2).
22. H.R. 3486 § 3(3); S. 1770 § 4202(3); S. 1658 § 3(3).
23. H.R. 3486 § 3(4); S. 1770 § 4202(4); S. 1658 § 3(4).
24. H.R. 3486 § 3(5); S. 1770 § 4202(5); S. 1658 § 3(5).
25. H.R. 3486 § 3(7); S. 1770 § 4202(7); S. 1658 § 3(7).
26. H.R. 3486 § 4; S. 1770 § 4203; S. 1658 § 4.
27. See, Statement of Anne K. Bingaman at 5, supra, n. 13.
28. H.R. 3486 § 5; S. 1770 § 4204; S. 1658 § 5.
29. H.R. 3486 § 6; S. 1770 § 4205; S. 1658 § 6.
30. H.R. 3486 deems either ventures below these size limits or ventures wherein providers share risk to have notified the agencies. S. 1658 and S. 1770 require both size limits and risk sharing before ventures will be deemed to have notified the agencies.
31. 15 U.S.C. § 15 (West Supp. 1994).
32. Health Security Act. H.R. 3600, 103rd Cong., 1st Sess., § 1322(c); S. 1757, 103rd Cong., 1st Sess., § 1322(c).

Number of People Receiving Their Care in an HMO (in millions)



Source: GHAA

**Number of HMOs and HMO Enrollment by State,
December 31, 1993**

	Number of HMOs 12/31/93	HMO Enrollees 12/31/93	Percent Enrollment of Total Population
50 States, plus Guam	545	45,205,347	
50 States, excluding Guam	543	45,126,556	17.4%
Alabama	9	267,361	6.4%
Alaska	0	0	0.0%
Arizona	19	1,302,851	32.9%
Arkansas	5	67,281	2.8%
California	40	10,999,128	35.0%
Colorado	14	834,967	23.2%
Connecticut	14	805,928	24.5%
Delaware	4	120,753	17.2%
District of Columbia	3	218,368	37.6%
Florida	35	2,414,714	17.6%
Georgia	9	495,949	7.1%
Guam	2	78,791	n.a.
Hawaii	6	263,172	22.3%
Idaho	1	11,926	1.1%
Illinois	26	1,890,512	16.1%
Indiana	12	384,205	6.7%
Iowa	3	106,194	3.8%
Kansas	9	191,997	7.5%
Kentucky	6	250,223	6.6%
Louisiana	9	305,392	7.1%
Maine	2	53,637	4.3%
Maryland	14	1,598,083	32.0%
Massachusetts	16	2,063,481	34.1%
Michigan	17	1,753,593	18.4%
Minnesota	9	1,366,552	30.1%
Mississippi	1	3,200	0.1%
Missouri	18	752,900	14.3%
Montana	1	11,390	1.4%
Nebraska	5	108,975	6.7%
Nevada	6	176,883	12.7%
New Hampshire	2	153,356	13.6%
New Jersey	10	1,026,143	13.0%
New Mexico	6	254,664	15.7%
New York	34	3,919,013	21.4%
North Carolina	10	459,392	6.6%
North Dakota	1	3,008	0.5%

**Number of HMOs and HMO Enrollment by State,
December 31 , 1993**

	Number of HMOs 12/31/93	HMO Enrollees 12/31/93	Percent Enrollment of Total Population
Ohio	32	1,698,013	15.2%
Oklahoma	5	235,841	7.3%
Oregon	7	959,573	31.5%
Pennsylvania	20	2,293,233	18.9%
Rhode Island	3	260,552	25.9%
South Carolina	4	119,892	3.3%
South Dakota	1	20,890	2.9%
Tennessee	11	291,286	5.7%
Texas	26	1,757,713	9.7%
Utah	8	345,612	18.5%
Vermont	1	64,480	11.1%
Virginia	12	468,605	7.2%
Washington	11	803,847	15.2%
West Virginia	0	0	0.0%
Wisconsin	26	1,171,819	23.1%
Wyoming	0	0	0.0%

Source: GHAA's National Directory of HMOs database.

Mr. BROOKS. Our final witness is Ms. Kelly Traw. Ms. Traw is manager for public policy with the Washington Business Group on Health.

We are delighted to have you here.

**STATEMENT OF KELLY TRAW, MANAGER, PUBLIC POLICY,
WASHINGTON BUSINESS GROUP ON HEALTH**

Ms. TRAW. Thank you, Mr. Chairman.

The Washington Business Group on Health is an organization of Fortune 500 employers. We have been involved in public and private sector efforts to improve health care delivery and financing since 1974. Our member companies have evolved from passive payers to active purchasers of health care on behalf of approximately 30 million employees and dependents.

On behalf of our members, I appreciate this opportunity to share with you our comments on antitrust issues in health system reform.

For managed competition to work, in improving quality and lowering costs, we need sound and vigorous enforcement of antitrust law. We encourage Congress to avoid statutory antitrust exemptions that would weaken the protection afforded consumers by the current antitrust laws.

We support continued guidance from the agencies with enforcement authority and urge the sound application of antitrust laws to all participants in the health care industry.

Health care reform began within the business community, where it continues at an accelerating pace. Employers have been asking hard questions about what their money is buying from providers. Their market clout has allowed employers to work with providers to get better quality health care at a lower cost. And the integration of providers into organized systems of care is crucial to this success.

Our member companies are moving away from purchasing the services of individual providers to purchasing the services of a system of care. The collaboration between purchasers and providers has created some high-quality innovative health care delivery systems. Antitrust laws play a crucial role in ensuring the continuing development and improvement of these systems while protecting consumers from the ill effects of price fixing, boycotts, market allocation schemes, and other anticompetitive conduct.

As large purchasers of managed care products, our members want to ensure that this antitrust protection is preserved in health system reform. Several pending health reform bills would grant special treatment for certain providers of the health care industry.

No compelling need exists to justify this special treatment. We are aware of no empirical evidence that reflects the need for such provisions to protect consumers. We believe writing such provisions into legislation is ill-advised at this time. Antitrust enforcement has generally been flexible enough to prevent anticompetitive harmful conduct while allowing procompetitive ventures that benefit consumers. Statutory exemptions would eliminate this flexibility to respond to changes in the health care industry.

Some providers have protested that antitrust law impedes their participation in procompetitive, even consumer protection activities. However, these protests often reflect the mistaken perception of the law, not a need for statutory changes. Ongoing communication from the enforcement agencies helps educate participants in the health care industry and diminishes any inhibiting effects caused by uncertainty and misimpressions.

In addition to the potential harm caused by statutory provisions, mandatory review schemes raise substantial concerns. We are aware of no need that would justify such a complex bureaucratic scheme and the sanctioning of any and all activities relating to health care services contained in an application. Such broad regulatory oversight would impose an immense burden on the Department of Justice to prospectively detect and continually monitor approved health care activities.

The Department of Justice would have an ongoing responsibility to ensure that no such activities subsequently created anticompetitive effects, and in the event they did, to intervene in a regulatory manner. This could needlessly hinder the Department in carrying out its enforcement activities.

We also believe that allowing individual competitors to join together for the purpose of negotiating fees would inevitably result in higher prices in the health care market. Much of the success employers have experienced in containing health care costs has relied on competition among providers to achieve a reasonable price for quality services. Eliminating competition among individual physicians and granting them exemptions from antitrust law to essentially collude in fixing prices would seriously undermine the purchaser's ability to negotiate high-quality health care at a reasonable price.

In sum, no statutory modification of antitrust law is necessary in health system reform. Providers are working with one another and with employers and other purchasers of health care to improve the quality of and access to health care under the protection of current antitrust law.

We emphasize the need to consider quality and access factors in the application of antitrust law and encourage ongoing guidance from the enforcement agencies. But we strongly support the continued enforcement of current antitrust law in health system reform with no exemptions for special interests.

We thank the committee and the chairman for this opportunity to share our views.

[The prepared statement of Ms. Traw follows:]

STATEMENT ON

H.R. 3600, THE "HEALTH SECURITY ACT" --
ANTITRUST ISSUES

BEFORE THE

COMMITTEE ON THE JUDICIARY
ECONOMIC AND COMMERCIAL LAW SUBCOMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

PRESENTED BY

KELLY L. TRAW, J.D.
MANAGER, PUBLIC POLICY

JUNE 15, 1994

INTRODUCTION

Good morning Mr. Chairman. My name is Kelly Traw, and I am manager of public policy for the Washington Business Group on Health (WBGH). On behalf of our members, I appreciate this opportunity to share with you our comments on antitrust issues in health system reform.

WBGH is an organization of Fortune 500 employers that has been involved in public- and private-sector efforts to improve health care delivery and financing since 1974. WBGH member companies have evolved from passive payers to active purchasers of health care on behalf of approximately 30 million Americans.

For managed competition to work in improving quality and lowering costs, we need sound and vigorous enforcement of antitrust law. WBGH encourages Congress to avoid statutory antitrust exemptions that would weaken the protection afforded consumers by the current antitrust laws. We support continued guidance from the agencies with enforcement authority and urge the sound application of antitrust laws to all participants in the health care industry.

ORGANIZED SYSTEMS OF CARE

Health care reform began within the business community, where it continues at an accelerating pace. Employers have been asking hard questions about what their money is buying from providers. Their market clout has allowed employers to work with providers to get better quality health care at a lower cost, and the integration of providers into organized systems of care is crucial to this success.

As large purchasers, WBGH members use their access to information on thousands of covered lives to make informed purchasing decisions to meet the needs of employees and their dependents. Underlying these decisions is a focus on the way health care is delivered. By working with providers to improve the delivery system, WBGH members are able to address the discrete problems in health care, including the uncontrollable costs, the variable and often unknown quality, and the unequal access.

This collaboration between purchasers and providers has created some high quality, innovative

health care delivery systems. These systems encompass the cooperation of a broad range of providers, the provision of comprehensive services, the availability of all information useful to consumers, and administrative ease. Antitrust laws play a crucial role in ensuring the continuing development and improvement of these systems while protecting consumers from the ill effects of price fixing, boycotts, market allocation schemes and other anticompetitive conduct.

WBGH members are moving away from purchasing the services of individual providers to purchasing the services of a *system* of care. Consequently, WBGH members are large purchasers of managed care products. For example, in 1992, 60% of employees of ALCOA were enrolled in managed care networks. At Xerox, 62% were enrolled in HMOs, and at Digital Equipment Corporation HMO enrollment was at 70%. These high enrollment rates reflect these companies' discovery that well-managed organized systems of care are the best means of improving quality while controlling the costs of health care.

Applying to health care many of the continuous quality improvement principles that industry has used successfully in developing and marketing their products, employers are working with providers to improve the quality of the health care delivery process. Integrating continuous quality improvement processes, placing a high value on patient/member satisfaction, carefully selecting providers from a multidisciplinary panel of providers, and holding plans accountable to the purchasers and consumers of health care all contribute to increased quality of care. For these elements to be effective, an integrated system of care is necessary.

By working with providers to develop organized systems of care and improve the quality of care, employers are also achieving lower costs. In 1991, ALCOA estimates that the cost savings from its managed care plans were \$8 million in 1992, with 60% of its employees enrolled in networks. CALPERS is even experiencing a negative cost trend, an unusual occurrence in today's health care market.

These significant savings, combined with the ability to improve quality, reveal why employers care about preserving antitrust protections in the health system reform debate. Antitrust laws allow these organized systems of care to develop and compete on price and quality. Large employers want to ensure that this antitrust protection is preserved in health system reform.

NO STATUTORY IMMUNITIES

Several pending health reform bills would grant special treatment for certain providers in the health care industry. No compelling need exists to justify this special treatment.

Antitrust enforcement promotes consumer welfare by allowing providers to compete in meeting the needs and demands of consumers, especially through innovative health care delivery systems. As health care providers arrange themselves into competing organized systems of care, antitrust law will play an increasingly important role in the health care industry to ensure the efficient allocation of resources through the free market forces of supply and demand. Special statutory treatment for any participant in the health care industry would only distort the market by creating

artificial winners and losers.

Artificial protections for providers through statutory revisions to antitrust law are unnecessary to allow competition to work in the health care marketplace and even pose significant risks for consumers, as Assistant Attorney General Bingaman pointed out in her April 14 letter to Senator Metzenbaum.¹ We are aware of no empirical evidence that reflects a need for such provisions to protect consumers, and we believe writing such provisions into legislation is ill-advised at this time. Antitrust enforcement has generally been flexible enough to prevent anticompetitive, harmful conduct while allowing procompetitive ventures that benefit consumers. Statutory exemptions would eliminate this flexibility to respond to changes in the health care industry.

The original antitrust statutes are very brief; the rich body of antitrust law that governs American free markets has been primarily developed by the courts and applied by the enforcement agencies. This body of law contains the flexibility and protection for providers to collaborate in procompetitive activities, including the creation of organized systems of care that compete with each other to provide high quality health services and products efficiently and at a reasonable cost. This body of law also contains the power to prohibit collusive activities that would harm consumers or prevent other providers from competing in the marketplace.

Moreover, the history of antitrust enforcement in the health care industry does not reveal a need for special treatment for any participant in the health care market. Indeed, antitrust enforcement by the Federal Trade Commission and the Department of Justice has been crucial to the

development of these innovative alternatives to traditional fee-for-service medicine. Actions to prevent price-fixing conspiracies, tying arrangements, anticompetitive restrictions on non-physician providers, and "sham" joint ventures are illustrative of the important role antitrust enforcement has had in allowing organized systems of care to develop.

Hospital mergers and joint ventures also provide a good example. As noted in Acting Director Steptoe's May 12 testimony to the Senate Finance Committee,² no hospital joint ventures and very few hospital mergers have been challenged by the enforcement authorities. The vast majority of hospital mergers and joint ventures are viewed as procompetitive, enhancing efficiency and promoting competition.³ Recent reports by the Health Care Task Force of the American Bar Association and the Department of Health and Human Services concur that antitrust enforcement has not deterred hospital mergers.⁴ Rather, consolidation has reduced wasteful overcapacity in the system and produced more efficient and cost effective providers.

GUIDANCE FROM ENFORCEMENT AGENCIES

Some providers have protested that antitrust law impedes their participation in procompetitive and even consumer protection activities. However, these protests generally reflect a mistaken perception of the law, not a need for statutory changes. Ongoing communication from the enforcement agencies should educate participants in the health care industry and diminish any inhibiting effects caused by uncertainty and misimpressions. These efforts include such formal measures as the issuance of Policy Statements,⁵ the expedited provision of Business Review

Letters and Advisory Opinions, and the presentation of public speeches by enforcement agency officials as well as informal discussions between agency staff and providers.

Indeed, we laud the Department of Justice and the Federal Trade Commission for their unprecedented efforts to provide guidance on antitrust enforcement policy in the health care area. Their commitment to the ongoing provision of this guidance as well as an expedited review process will go far to address provider concerns about the antitrust laws. Sound enforcement policy, articulated clearly and comprehensively, will clarify for participants in the health care industry the scope of permissible activities, yet retain the government's and providers' flexibility to respond to industry changes over time.

CERTIFICATE OF REVIEW SCHEME

In addition to the potential harm posed by statutory revisions, mandating a certificate of review scheme raises substantial concerns. Proposed legislation would provide complete antitrust immunity to providers who obtain a certificate of review from the Attorney General. A certificate would have to be granted if the proposed activities met specified criteria and the benefits of the activities outweighed the disadvantages.

A tight time deadline (ninety days) would be imposed on the Attorney General in responding to parties' requests. If the deadline is not met, the proposed activities would automatically be deemed approved and given antitrust immunity. The Federal Trade Commission, with its

extensive expertise in analyzing health care markets, would be excluded from the process; the Attorney General would make determinations in consultation with the Secretary of the Department of Health and Human Services.

We are aware of no need that would justify such a complex bureaucratic scheme or its function of sanctioning any and all activities relating to the provision of health care services contained in an application. Such broad regulatory oversight of health care activities would impose an immense burden on the Department of Justice to prospectively detect and continually monitor approved health care activities. The Department of Justice would have an ongoing responsibility to ensure that no such activities subsequently created anticompetitive effects and, in the event that they did, to intervene in a regulatory manner. This could needlessly hinder the Department in carrying out its enforcement responsibilities.

Furthermore, such a process would entail substantial, additional costs. In addition to the transaction costs associated with the application process, it would inevitably lead to another layer of litigation, based not on the merits of the proposed venture but on whether the relevant activities should have been granted immunity under the criteria specified in the legislation.

JOINT FEE SCHEDULE NEGOTIATION

WBGH believes that allowing individual competitors to join together for the purpose of negotiating fees would inevitably result in higher prices in the health care market. Much of the

success employers have experienced in containing health care costs has relied on competition among providers organized into organized systems of care to achieve a reasonable price for quality services. Eliminating competition among individual physicians and granting them exemption from antitrust law to essentially collude in fixing prices would seriously undermine the purchaser's ability to negotiate high quality health care at a reasonable price. Current antitrust law does allow physicians to jointly negotiate fees, as long as the safeguards of substantial financial risk sharing or integration are present.

CONCLUSION

No statutory modification of antitrust law is necessary in health system reform. Providers are working with one another, and with employers and other purchasers of health care, to improve the quality of and access to health care under the protection of current antitrust law.

Tremendous strides have been made in this effort. We emphasize the need to consider quality and access factors in the application of antitrust law and encourage ongoing guidance from the enforcement agencies. But we strongly support the continued enforcement of current antitrust law in health system reform, with no exemptions for special interests.

WBGH thanks the Committee and the Chairman for this opportunity to share our views.

1. See, Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to the Honorable Howard W. Metzenbaum, Chairman, Subcommittee on Antitrust, Monopolies and Business Rights, Committee on the Judiciary, April 14, 1994.
2. See, Prepared Statement of Federal Trade Commission, presented by Mary Lou Steptoe, Acting Director, Bureau of Competition, Federal Trade Commission, before the Committee on Finance, United States Senate, May 12, 1994.
3. Of the more than 250 hospital mergers since 1987, the Federal Trade Commission or the Department of Justice have conducted only thirty formal investigations and have challenged only 13 hospitals mergers.
4. See, American Bar Association Working Group on Health Care Reform, "Antitrust Implications of Health Care Reform," (May 14, 1993); "Report of the Secretary's Task Force on Hospital Mergers," Department of Health and Human Services (January 1993).
5. See, Statements of Antitrust Enforcement Policy in The Health Care Area, U.S. Department of Justice and the Federal Trade Commission (September 15, 1993).

Mr. BROOKS. Ms. Steptoe, how would the regime suggested by the AMA, under which the antitrust enforcement agency would sit in judgment on the proposed antitrust exemptions, change the way antitrust enforcement functions in our economy?

Ms. STEPTOE. Well, sir, I think it would change extremely in a couple of ways. First, as I have mentioned, there would be whole areas where we have traditionally looked at anticompetitive activity that we would now be barred from review. The collective negotiation of fees just mentioned, when the parties involved represent less than 25 percent of the specialists in the area, would be one example.

Another would be a whole category of hospital mergers encompassing middle-size hospitals—we would be barred from looking at these mergers as well.

And then the third area refers to the certificate-of-review process. I should really at this point defer to AAG Anne Bingaman, because she is the one who has articulated the issue to the greatest extent. That is going to create, in her words, a “massive new bureaucracy.” It is going to really change the way antitrust review is done in the United States. Instead of looking for violations of the antitrust laws, the Department of Justice, she notes, will be kept busy trying to review all these requests for a certification.

And there are several dangers she outlines in that. The first is their resources will be diverted from their traditional activities. The second is, if the Antitrust Division is inundated with these requests, that they may not even be able to review those requests adequately. There are very strict time lines for acting on any request, in essence, a negative-option procedure. If the Department of Justice hasn’t ruled in a certain period of time, then the practice is presumed to be legal. She is concerned, as I am, that some things will slip through the cracks.

Moreover, the new regime will give the Department of Justice oversight over the whole health care industry. It will impose costs on the industry as well as costs on the Antitrust Division.

So I think taken collectively that is a revamping of the whole antitrust system.

Mr. BROOKS. One other question, Ms. Steptoe. How do you respond to the doctors’ complaint and genuine concern that the guidelines treat doctor-led health plans differently from insurance company-led health plans? They are concerned about the insurance companies.

Ms. STEPTOE. Yes, sir. I think there are a couple of things that need to be addressed in that complaint. The first is, to get the record straight, the Federal Trade Commission has never said that doctors can’t manage or run health care plans. And, in fact, it issued a policy statement back in 1981 that goes into some detail about just how doctors can do so.

We have heard this morning that there are quite a number of health care plans out there that are doctor-managed and doctor-led, so there is clearly no antitrust bar to that happening.

The issue is the same issue as in any joint venture analysis. Doctors can engage in any business they want, even bringing competitors together, as long as they are integrated enough, financially integrated such that they are sharing financial risk as well as reaping the benefits of what they do. And that is because if they are at risk collectively, then their incentives are changed.

Their personal incentive to bill to the maximum is subordinated to the incentive of the organization, which is to contain cost, because that is how it is marketing itself, as an organization that can bring something new to the marketplace, in the form of lower costs or greater innovation.

So the answer is, first of all, the problem is less than appears. The second part of my answer addresses your question, which I understand to be: Isn't it exactly the same for an insurance company to line up 60 or 90 percent of the doctors in a community on its panel, as if 60 or 90 percent of the doctors in the company bargain collectively with that insurance company? And the answer is, no, it is not the same. It is vastly different.

If you will give me a second, I think I can attempt to explain it. When you are talking about the managed care plan signing up a significant portion of doctors, remember, it does so one doctor at a time: individually negotiated contracts trying to get for its subscribers the best mix it can of doctors at the best price, the best spread of specialties, the best location, the best terms.

And when it ultimately has accrued 60 percent, that is going to benefit the consumers. They now have a wide-ranging plan. Don't forget also in the majority of cases these doctors who are signed up with one health plan are also free at the same time to continue their own private practice or even sign up with competing health plans, so that the community is benefiting from an increase in its health care option.

The contrast is when you get those 60 percent of doctors doing nothing more than aligning themselves for bargaining purposes. What is the goal there? The goal is to get higher fees for them. That is, higher premiums for the subscribers, and probably also reduced choice to the subscribers.

There is no consumer benefit in that situation. So what looks like an equation is not. It is two completely different scenarios. One is anticompetitive and one is proconsumer.

Mr. BROOKS. Dr. Delmer or Dr. O'Neil-White, do you want to comment on that? Doctor.

Dr. DELMER. It seems to me the appearance could be gained that AMA is on one side of all these issues and everybody else here is on the other side, and that is the furthest thing from the truth. We go back 5 years in establishing a plan and principles for AMA to pursue to make competition the issue by which health care reform can be introduced. That is a matter of record. Competition is the key, and we readily understand that.

We totally support the principle of fair price. We totally support all the principles of antitrust and the objectives of health system reform.

The problems that we find as we get out into the hustings is that we have one and two doctors working together and trying to carve out their own practices, and then in the midst of them, like deep

pockets, if you will, the big corporate entities. They are given an opportunity to sign on if they want to, and generally it is sort of inferred that if you don't, the guy down the street will, and you will be left out in the cold.

So what is happening in the marketplace is that doctors are being herded, literally, into a situation where they can no longer effectively speak as directly for their patients' needs as they have been able to in the past. That is purely and simply what we would like to accomplish. We are not looking to do away with antitrust. We fully appreciate its importance.

We are not looking to exempt ourselves from it. We are looking for ways to work within the system to enhance competition by having more doctors able to come together and compete.

Think about it. If they come together only for the purpose of raising fees, they can't compete. It will be anticompetitive and they won't be able to survive. If you give them the opportunity to come together and plan and organize and do things, they can then get into the market and make their way without having to be tied to an HMO or some similar activity.

We are not against HMO's. They have a role. But you can't go from a doctor working by himself into an organization of the type that are out there overnight. The doctors need to come together in little groups and talk about what we can do to compete.

Mr. BROOKS. Mr. O'Neil-White, do you want to comment on that question?

Mr. O'NEIL-WHITE. Thank you, Mr. Chairman.

GHAA is a firm supporter of the current antitrust framework, because that framework has allowed the HMO industry to succeed, to even exist today as the only effective alternative to fee-for-service medicine in the country today. And the HMO industry, because of its effectiveness, we believe, is a driving force behind health care reform in the country today. We have demonstrated that we can provide high-quality health care at affordable rates and make it accessible to consumers.

I would point out that the HMO industry was founded by consumers as an alternative to fee-for-service medicine. In response to Dr. Delmer's comments, we do believe that physicians must compete in the marketplace.

I think the thrust of the AMA's position is that physicians somehow should be protected from competition. And the example that he used indicates that those two physicians who are approached by an HMO in the marketplace must compete with each other. I think the AMA doesn't want that to occur. They must compete with each other by demonstrating they can provide high-quality health care at affordable prices, convenient to the consumers if they are going to get into that network.

They weren't competing with that health plan. They are competing with other physicians in the marketplace. We think that is healthy. We think that provides a real service to the consumer.

Mr. BROOKS. Ms. Steptoe, some have claimed that the primary danger in an exemption for fee negotiations is that it might shield group boycotts. What is your view, as an antitrust enforcer, as to whether other anticompetitive conduct might also be implicated?

Ms. STEPTOE. Well, sir, I would reference the Commission's opinion in the Michigan Medical Society matter. I think it touches on this issue. The Commission noted that the bargaining/negotiation process carries with it an implication of adverse consequences. At some point the presentation of views, vigorous, forceful, and so forth, slips over into a threat which may be implied or may be direct. And the threat is, if you don't accept these views, I am not going to deal with you anymore, I am going to walk away from this bargaining table.

Now, obviously, the greater power you have on one side of the bargaining table, the greater collective power you have, and the more implicit that threat becomes. So as an antitrust enforcer, I worry that "collective negotiation" as a phrase is sending out a mixed message. On the one hand, it can be benign, it can be presentation of views; and on the other hand, it can make that slip that the Commission referenced and be very close to, if not preliminary to, to a boycott.

I think ambiguities like that are troublesome not only to me as an antitrust enforcer but they should be troublesome to the providers, because it doesn't give them a clear direction of just how far they can go.

Mr. BROOKS. I would like all of you to think about this one. How do you respond to those who say antitrust exemptions for doctors are needed to level the playing field between them and the large health insurance companies?

Let's start at the other end. Do you have a comment on that, Ms. Traw?

Ms. TRAW. It has been our experience that the antitrust laws allow physicians to compete in the health care industry. And it is our concern that these antitrust exemptions will create an imbalance in the competition in the marketplace. Strong, sound enforcement of current antitrust laws are the best means of ensuring competition and to protect consumers, as well as to allow purchasers to negotiate reasonable prices and improve the quality of health care with providers.

Mr. BROOKS. Mr. O'Neil-White.

Mr. O'NEIL-WHITE. Thank you, Mr. Chairman.

We don't believe that there is a need for antitrust reforms to allow for a level playing field. We think that we have one now, that physicians are able to engage in a wide variety of activity, and they are currently doing that in the marketplace.

There are physician-owned PPO's, physician-owned HMO's, integrated delivery systems, physician-hospital organizations. They are all doing quite well today. And I think they are doing that under the current framework.

We don't think that—as I pointed out before, I think there is this misconception that physicians in the marketplace are competing with health plans. They aren't. They are competing with other physicians, other sellers of health care services.

The suggestion that marketplaces are being dominated by large corporate entities just doesn't bear out. The facts just don't support that assertion. The suggestion that 70 percent of the people in Austin, TX, are in HMO's is no indication that one or two plans dominate that marketplace. We suggest—we submit that there are a

number of health plans operating in that marketplace, and physicians have the opportunity to move within those health plans.

So we believe that the current laws encourage that kind of pro-competitive activity. And as a result are a benefit to the consumers.

Mr. BROOKS. Mr. McGlothlen.

Mr. MCGLOTHLEN. Yes, sir. The level playing field is extremely important to us. When you weaken the antitrust laws, anticompetitive behavior occurs. An example of anticompetitive behavior in Colorado was requiring that the anesthesia provider in a hospital own his own anesthesia machine. A machine costs around \$60,000 or \$70,000. I was told I could not do an anesthetic in a hospital unless I owned a machine. That was clearly anticompetitive and it came out in my antitrust lawsuit. I had to go out and purchase a \$60,000 to \$70,000 machine to do a \$300 anesthetic. It was a way of restricting competition.

If you weaken the antitrust laws, it will allow anticompetitive behavior. And it definitely will take the choice away from the consumer.

Mr. BROOKS. Dr. Delmer.

Dr. DELMER. Well, anticompetitive activities in the medical field are not acceptable to the medical field, and should not be acceptable to the public, and we wouldn't be here to speak for them. The issue is a level playing field. The level playing field has a lot to do with resources. And doctors are famous for nice incomes, but they are not famous for having huge sums of money to invest in creating a plan of the nature that the insurance industry is doing.

I would like to point out to you that in Minneapolis, 44 percent, I believe, of the people there are taken care of by health maintenance organizations. Recently, within the past year, four of the largest competitive plans have merged to where there are only two now. And this is the direction that we see going.

This is what is happening, and this is what our concern is based on. We see the control of the practice of medicine moving from what is important between the patient and the physician over to what is important to the bottom line of the industry.

We don't have any problem with competing if we are given the opportunity to. We have had constructive discussions working with the Department of Justice and the Federal Trade Commission. We would like to see that continue.

We are very flexible as to how we get to where it is easier for doctors to come together and remain in charge of medical care, not set prices, not be anticompetitive, simply make it the best way we can for the patient. You have to believe me that that is what we are about. And we hope we can discuss this with all these parties so we can get it together.

Mr. BROOKS. Doctor, it is hoped that individual doctors can still practice, and I can go to the doctor I want, if I want to pay him. If he is competitive with HMO's or some managed care, but I like Dr. So-and-so and I want to go to Kabala for something, I can still go down there and pay him, can't I? I think we are going to have that possibility.

Dr. DELMER. I hope you will be able to continue to do that.

Mr. BROOKS. I think we are going to have that competition.

Dr. DELMER. That is what we want to say.

Mr. BROOKS. That is what they are arguing about, isn't it? I think it is when they get in groups and negotiate those prices that you have a controversy. There is no controversy about my going to any doctor I want to and paying him as he competes with HMO's and managed care and company plans and group plans and insurance. I just like old Kabala because he is a good man and I can go if I want to, and he can compete with all of them. That is not a problem.

Dr. DELMER. The problem Dr. Kabala would have is being able to come together with a group of physicians in order to have purchasing power of supplies to curtail the cost of his doing business in his office. That is real. That is real.

Mr. BROOKS. If they are not a cartel and it is just a purchasing group, there wouldn't be any violation of antitrust laws. I don't think you would have Ms. Steptoe raising Cain with you, if you just want to be a purchasing group. If it is price fixing and some other things, you will get into problems. But if it is just purchasing—what do they purchase?

Dr. DELMER. Medical supplies and any number of things. Lots of overhead in the doctor's office.

Mr. BROOKS. Mostly nurses and bookkeepers and accountants, receptionists, assistants. Those are all components of a practice.

Dr. DELMER. About half of it is—

Mr. BROOKS. Most doctors don't use that many bandages, do they?

Dr. DELMER. I don't know about Dr. Kabala, but—

Ms. STEPTOE. I just wanted to make a couple of brief points, because a lot has already been said. On the whole, this specter of the monolithic buyer and the doctors being told: "Deal with me or else," has not been shown to be the case.

For the most part, as you mentioned, there are a number of purchasers in any given market. There is employer insurance, traditional insurance, HMO's, Blue Cross/Blue Shield, etc. There is a lot of rivalry on the buyers' side.

But the point I really want to make is this. It seems that a lot of this legislation, if not all of it, is aiming at cost control through coordinated purchasing. And it simply seems counterintuitive to set up power on the other side of the situation.

If you are trying to do coordinated purchasing to impose cost control on the medical system, you would at least question whether you are undermining that goal by beefing up the other side of the bargaining table.

Mr. BROOKS. One further question. Mr. McGlothlen, the proposed antitrust exemption in the Health Security Act for collective fee negotiations would apply not just to doctors, but to all health care providers. Now, why does your group not favor getting an antitrust exemption?

Mr. MCGLOTHLEN. Well, certainly the phrase health care providers means one thing to one person and one thing to another. Many times in the real world, health care provider is limited to meaning physician. The word nonphysician clearly delineates who I am. Nonphysicians include CRNA's, nurse-midwives, optometrists, occupational therapists—all of whom are concerned about the weakening of antitrust laws.

I work with two anesthesiologists in a small town. We practice side by side. They are clearly concerned with the weakening of the antitrust laws because they feel that other large anesthesia groups will move in and take over their hospital through either HMO's or other health plans and will negotiate deals they are not even privy to. So it is a concern of all providers who do not have strong negotiating power.

Within my own profession of anesthesia some people would use the weakening of antitrust laws to control the market and decrease competition.

Congress in 1986 gave CRNA's the right to directly bill Medicare. In the State of Colorado at that time, only 7 percent of the anesthesiologists accepted assignment under Medicare; i.e., didn't balance bill patients. Today, over 70 percent of anesthesiologists accept Medicare assignment. CRNA direct reimbursement drove the price down and drove the competition up. And that was a benefit to the consumer. So that is why we feel that the antitrust laws should not be changed.

Mr. BROOKS. Mr. Fish, the distinguished gentleman from New York.

Mr. FISH. Dr. Delmer, you note in your testimony that the AMA has met with officials of the Department of Justice and the FTC about the remaining contentious issues. Those would be possible additions, changes, and clarifications in the antitrust policy statements.

Could you tell us what is the current status of these discussions and could you describe for the subcommittee the principal areas where the AMA is seeking further protection?

Dr. DELMER. I may not be able to answer your question as thoroughly. Not being an antitrust attorney, I am hampered in this. But what I can tell you that gives us need for some legislative relief has to do with the means by which the Department of Justice and the Federal Trade Commission issue guidelines.

That is done without the notice and public comment requirements of the Administrative Procedure Act. We have precious little opportunity for input until the agencies have gotten together and decided what initiatives to take.

When they do take action, very often we found they are restrictive in the sense of what can we do and then the attorneys we spend money on to hire, we find tell us that you better not do that because FTC will be down on you. And those are frightening words. They will scare any doctor in the country out of his wits.

Finally, if we take a step as a result of a guideline, we cannot count on that being a defense. Doing what you think was right according to the guideline does not in fact protect you when you get into the court to defend yourself, even though you have acted in good faith.

Mr. FISH. I understand the policy statements are still evolving; is that not correct, Ms. Steptoe?

Ms. STEPTOE. Yes. If I could pick up on what Dr. Delmer said, both agencies have been meeting with representatives of the health care industry, and that includes the doctors, the hospitals, the nonphysician providers, and so forth. And I have to say in terms of meeting with representatives of the AMA and other doctor

groups, barely a week has passed that we haven't met with them. We are exploring what their concerns are and talking the issues over. The process is not one where the agencies just passively listen. It is 3- or 4-hour sessions where we discuss the issues in great depth.

Mr. FISH. Not a blank wall. A blackboard. So I take it the doctor said he is not an antitrust lawyer, but there are antitrust lawyers who are known to have problems with the policy statements. I presume that they are in touch with you and letting you know their concerns with the policy statements.

Ms. STEPTOE. Yes. We are evaluating both the policy statements and the need for further policy statements in other areas.

Mr. FISH. I think doctors generally would like more guidance than they have received so far, as to what they actually can do in terms of negotiating with a managed care company without getting into trouble.

OK. Now this question actually is for you, Ms. Steptoe, and for you, Mr. O'Neil-White. This is parochial on my side, as it deals with rural areas. I am concerned about the special problems faced by rural areas with respect to health care.

I think when a lot of us talk about health care, it is predominantly from an urban perspective. In Washington, DC, for example, we have many fine choices of doctors, hospitals, HMO's. I'm talking here not just about Kansas and Wyoming—I'm talking about upstate New York. And my question is, isn't there a downside to having one set of rules that fits all—such as the antitrust policy statements on hospital mergers? Don't the antitrust laws sometimes interfere with the ability of rural citizens to obtain the health care that they need?

Ms. STEPTOE. My answer is, no, there is no downside to a one-size-fits-all. There would be if it was a straitjacket, but it is a very flexible set of rules.

When we evaluate mergers, the first question we ask is, what is the product market? The second is, what is the geographic market? If you are in a rural area, the chances are that the geographic market is quite extensive. And right away you are looking beyond the issue of what might appear to be a merger to monopoly of, say, the only two hospitals in a town. You might find that they are competing hospitals much further out than you would, say, if you were looking in the Washington, DC, area.

And I think our analysis allows us to take into consideration the special factors, whatever they may be, of supply and demand that pertain in a rural market.

Mr. FISH. While we are talking "flexibility," your word, what about the fact that to qualify for the hospital merger safety zone under your guidelines, a hospital has to be 5 or more years old? Why is that? What if a hospital is in financially failing condition in a rural area and it is only 3½ or 4 years old? Why shouldn't that come within the same safety—

Ms. STEPTOE. If the hospital is in a failing condition, the otherwise anticompetitive merger would be allowed to go through under something called the failing company defense, which is in the one-size-fits-all set of merger guidelines, the 1992 DOJ/FTC Horizontal

Merger Guidelines. The guidelines allow for a failing company defense.

The reason why we have the aging requirement, the 5-year requirement, is because, despite the fact that people are saying that the hospital industry is overbedded and has problems, there actually are a lot of hospitals starting up, there are people building new hospitals throughout the United States today. These hospitals typically start off at a smaller level and grow, as you would expect. Few people open a 200-bed hospital on day one. They grow it. What you don't want to have happen is the incumbent hospital able to cherry-pick off its potential rivals by buying them up while they are still in their nascent stage. That is what that provision is attempting to prevent.

One final point, sir, if I may. Remember that the safety zone is an area where you know you can do the activity, but if you are outside the safety zone, that doesn't mean that you absolutely can't do whatever it is you want to do. It just means your conduct may be examined by the antitrust authorities.

And it may well be for all the reasons that you suggest about the special needs of a rural area that a hospital merger which fell outside the safety zone would nevertheless pass our review. The only difference is you would have to go through a review. If you were inside the safety zone, you wouldn't.

Mr. FISH. Mr. O'Neil-White, do you remember the question?

Mr. O'NEIL-WHITE. I do, and I think Ms. Steptoe did an excellent job of responding to it.

Our position is, while the rural areas are special, I don't think that they have a special problem that would require an exemption under the antitrust laws, for many of the reasons that Ms. Steptoe pointed out.

I would also point out to you that the HMO industry has accepted the challenge in the rural areas, and we have been able to bring health care services to those areas in a very forceful way.

And I would point out two examples. You mentioned New York. We have the Community Health Plan, which is based in Albany, as you might know. Twenty-six percent of its 300,000 members live in the rural areas of New York, Vermont, and Massachusetts, and they have been asked to come to some rural communities, and they have been able to come and bring adequate capital and resources, to expand health care services in the rural areas. They were invited to one small town, Hoosick Falls, when the town's only physician was ready to retire. The townspeople found Community Health Plan and asked them to come to that community. They came to that community.

That one physician decided not to retire. He became a part of their network. And that one town that only had one physician now has three physicians. So I think we have answered the challenge.

In Texas, the Scott and White Health Plan, a small HMO serving 100,000 members, and they have members in 20 Texas rural counties. And they have brought health care in. So I think that the HMO industry has been able to meet those needs in the rural areas, and we continue to move that way.

Mr. FISH. Ms. Steptoe, I will turn to unitary pricing. This concerns section 2003(e) of the proposed Health Security Act, H.R.

3600. This requires that a manufacturer of outpatient drugs must sell its products to any purchaser on the same terms and at the same price. My concerns are as follows:

(1) This effectively removes the pharmaceutical companies from the coverage of the Robinson-Patman Act;

(2) This language essentially repeals the Nonprofit Institutions Act for drug purchases; and

(3) It would drive up the cost of drugs nationwide.

Do you agree with this assessment?

Ms. STEPTOE. I will give a quick caveat, which is the Commission hasn't been asked to comment on this particular piece of legislation so we haven't reviewed it in-depth. I have to answer generally out of my own knowledge.

But I think I can certainly agree with your final point. Any time you are talking about leveling prices, you may be leveling some down, but you are leveling a lot of others up. And I would question from the get-go why you need to get rid of discount pricing, which obviously benefits consumers. I don't know too much of the details of the plan to comment in greater depth.

Mr. FISH. But wouldn't HMO's and hospitals be hurt by this provision, not being able to purchase drugs in volume at a cheaper rate?

Ms. STEPTOE. I don't know enough about how it would work out, about who would end up on the hurt side and who wouldn't as far as that goes. I guess I have gone about as far as I can go by suggesting that you might want to think about whether eliminating discounts is a good idea.

Mr. FISH. Isn't the Commission concerned about unitary pricing provision in the administration's bill? I understood that you were. I would think that some analysis by the FTC could lead to something that could be forwarded to this committee at a later date.

Ms. STEPTOE. Again, I can't say whether the Commission is or isn't, it hasn't reviewed the bill. But I would take, as a starting point, your reference to the fact that the bill is essentially replacing the Robinson-Patman Act with a different regime, and the Robinson-Patman Act, as you know, and certainly Chairman Brooks knows, prohibits discriminatory pricing, but it does so with a number of important questions that have to be asked before you find that there is something illegal about different prices between two customers.

And I gather that some of these questions will not be asked under this new regime. Questions like, is the difference in price because the favored customer is performing special services that entitle it to a lower price? or, secondarily, is the difference in price justified because the seller is meeting a competitive bid?

That is something we generally want businesses to do—respond to the competitive pressures of the marketplace, and on a spot basis move their prices down to a competitive level.

All those safeguards, I gather, are not going to be in this bill and those are ones I tend to think are appropriate, are good ones, and are ones currently used when making Robinson-Patman Act assessments.

Mr. FISH. It would be very helpful to have the Commission come down on this issue and let us know whether they think it is a wise provision or not.

Now, let me ask you something else. Your policy statements, yours and the Department of Justice, offer both the business review procedure of the Justice Department and the advisory opinion procedure of the FTC so that health care providers can find out the possible antitrust implications of their business choices. Has the advisory opinion procedure ever been used by the enforcement agencies as a means of obtaining information pursuant to an investigation or an enforcement action?

I am sure you are aware of the fact that concerns have been raised that the business review or advisory opinion process could actually have a chilling effect on medical practitioners that need antitrust advice.

Can you give us assurances that this hasn't happened, that it won't happen—that the very enforcement agencies that are giving these advisory opinions will not turn around and use the information received in an enforcement action?

Ms. STEPTOE. I guess I am not entirely following your question. You are asking, when someone comes to us and says, "I want advice on this planned course of conduct," would we then turn around and open an investigation into it?

Mr. FISH. You wear two hats, your business review for Justice, or your advisory opinion procedure if you are FTC, and you are also the enforcement agency. Here someone comes along and is telling you something, asking for advice, and there are various concerns about how the information that comes into your possession would be used. Could it possibly be used to actually adversely affect the person who is seeking your advice?

Ms. STEPTOE. There are two answers to that. I can't give you complete comfort. The most comfort I can give—and I think this should be a lot—is that if we tell an applicant their planned course of conduct is legitimate, there has never been an instance where we have gone back on that advice. We have never said 1 day, "That is fine," and then 2 days or 2 months or 2 years later, said, "See you in court on it."

On the other hand, if a proposed course of conduct were presented to us and we said this would violate the antitrust laws, and the parties then proceeded to go forward in spite of that clear advice and do precisely what has been advised against, then I think I would be remiss in my responsibilities if I didn't recommend an antitrust case or at least open an investigation.

I don't see how simply asking should shield—I mean, what if somebody came to me and said, I would like to engage in a price-fixing conspiracy with the following four people and I said, I advise strongly against it. If I later find out that they went ahead and fixed prices, should the fact that they came to me and asked me insulate them? I think not.

Mr. FISH. Many doctors are concerned about the limits on their ability to get together and negotiate fee reimbursements with

health insurance companies or managed care groups. Could you explain, for the record, what collective actions may lawfully be undertaken by physicians in these negotiations? Why shouldn't doctors be able to engage in "collective bargaining" just like unions can?

Ms. STEPTOE. Well, unions are allowed by law to engage in collective bargaining, and if you are not a union, then authority is not granted to you. What we always focus on is whether the doctors are financially integrated so that they have changed their operational incentives. We look to see if they have come together and formed something that is other than a mere association of competitors: for example, a physician group which has agreed to share risk by accepting capitation or by other financial incentives such as withhold arrangements that puts the group's plan ahead of any personal plan. If so, they can collectively negotiate prices, because that price negotiation, that agreement among competitors about price, is ancillary to a joint venture which is bringing to the marketplace a new form of competition.

If, on the other hand, the collaboration is nothing more than competitors who have not integrated their practices in any way, and are not engaging in cost-containment efforts in any way, they are not sharing anything at all except the united stand that "we will accept only this price and none other." That is, in my view, a price-fixing cartel, and does not benefit consumers. Its sole purpose and sole result is to raise the reimbursement rates to the cartel members.

Mr. FISH. Thank you very much.

Mr. BROOKS. Mr. Mann.

Mr. MANN. Thank you, Mr. Chairman.

I just have one question. I apologize if this was covered in your statements.

I want to focus on H.R. 3600 and the exemption that is proposed there for physicians and other providers to collectively negotiate. Is everybody except Dr. Delmer against that provision? What is your position, if you can tell me in turn?

Ms. Steptoe, do you want it start?

Ms. STEPTOE. As I was just saying, I think that the term "collective negotiation" is likely to encompass what I would call a price-fixing cartel of competitors who have not integrated their practices in any way, and who are together only for the moment, and the purpose is to get higher prices. Of course, it doesn't have to be that way. "Collective negotiation" can also encompass a scenario which I just spelled out.

But an exemption would mix up the bad with the good and would not allow the antitrust agencies to look and determine whether or not the collective negotiation had slipped over into the realm of boycott.

Dr. DELMER. I think the problem that the medical profession is being confronted with is going suddenly from what has been referred to as a cottage industry into an industry which is heavily organized and operated by people that make their livelihood by doing that. Getting from here to there is what this is all about, really.

Earlier, Congressman Brooks, you asked me, could you continue to go to see Dr. Kabala. And the answer is, you could, if you are willing to pay for it yourself, but you couldn't if he wasn't a part

of the plan that you got your insurance coverage from. And that in a nutshell is part of our problem.

The business of getting doctors to be able to come together is going to be a progressive one at best. If we take the existing situation in many towns, and small towns particularly, where they practice independently and keep their own books, and do their own thing, if physicians can get together and meet the competition that is out there from the insurance and HMO industries, then they could compete. That would be without going through all of the expense and steps of forming a big group practice.

The Mayo Clinic is a good example of what has evolved over the years. The Cleveland Clinic is another good example. But they are years and years into this process, and poor Dr. Kabala back here is just beginning to find out what it is all about. We are not prepared to jump from the frying pan into the fire just overnight. We need a little bit of herding. The doctor referred to this, like trying to herd cats. And there is a certain truth to that.

The medical profession has come a long way. In the last couple of years, it has come even further, and we are just looking for enough flexibility to continue to do that which we do best, and that is take care of patients and meet their needs. We don't want cartels or anything like that. We don't want to send him back to doing whatever he was doing before he was a nurse anesthetist. If there are things that look like they take away antitrust, that is not what we are after. Long answer to a short question.

Mr. MCGLOTHLEN. Well, I certainly don't want to go back to cutting grass in tank farms in Texas.

Mr. BROOKS. You don't want to do that. Too hot.

Mr. MCGLOTHLEN. But certainly we don't want to see any weakening whatsoever in the antitrust laws, which have worked for us in the past. The antitrust laws have protected the consumer. They have protected some providers. The emergence of groups of nonphysician providers as alternatives to physicians helps to lower costs and gives patients a choice.

If we weaken these laws at this point in time, some of the nonphysician providers who are now beginning to emerge will be stagnated. And weakening the laws will lower the quality of care, increase the cost, and lower the number of people that consumers can get health care services from. So, therefore, we are definitely against weakening the antitrust laws.

Mr. O'NEIL-WHITE. We would support the individual to my right. We oppose this exemption for the same reasons that Ms. Steptoe pointed out, this is collusive activity. Seventy-five years of Supreme Court review of the antitrust laws have indicated that whenever this activity is allowed, prices go up, and the consumers are disadvantaged. There is nothing in the Health Security Act that would convince us that that won't happen also in a reformed environment.

It simply legalizes illegal activity. We think it will lead to higher prices, and there is a danger that if you allow providers to collectively negotiate with the health alliances, that there will be a definite spillover to HMO's and PPO's and other providers in the marketplace, because these physicians will also have to be negotiating with those entities as well.

We think there is a serious danger of spillover and clearly there will be a great rise in prices, even if you have a global budget or caps or whatever, the prices will simply rise to the cap. Therefore, we oppose it.

Ms. TRAW. The Washington Business Group on Health also believes that the administration's collective fee negotiation provision raises substantial concerns. And I will echo essentially the points that were just made. We are concerned that this provision would inevitably result in higher prices in the health care industry and that there is a significant risk of spillover into other, nonfee-for-service sectors.

In our experience as purchasers in negotiating reasonable prices for higher quality care, we rely on competition among all providers. We believe this provision will pose a significant threat to our ability to that.

Mr. MANN. Thank you.

Thank you, Mr. Chairman.

Mr. BROOKS. Mr. Goodlatte, the gentleman from Virginia.

Mr. GOODLATTE. Thank you, Mr. Chairman.

Ms. Steptoe, one of the areas where there has been an awful lot of discussion about waste in the health care industry is in the processing of claims by the insurance companies. C. Everett Koop, the former Surgeon General, estimates that we waste \$120 billion a year, or 15 percent of the total amount of money that we spend on health care, because we do not have standardized forms. To some extent we have standardized forms already, but we need standardized procedures with the 1,500 different health insurance companies. I have talked to one small clinic in Roanoke, VA, my hometown. They have 10 physicians. They deal with 1,000 different insurance companies' claims. And they can't standardize the electronic transmission of their claims, nor can the insurance companies process them that way at the other end, because of the fact that we have 1,500 different procedures for processing claims, and there is no computer program that can do that.

So my question to you is, do you think that we need to change or set aside any of our antitrust laws in order to accomplish some standardization and, if so, do you think that is a good idea?

Ms. STEPTOE. Well, sir, I can't really answer your question for the reason that, as you know, the insurance industry is exempt from antitrust review. So there are constraints on the Federal Trade Commission from even studying or looking at it. So I would be trespassing on an area that I am barred from thinking about.

Mr. GOODLATTE. Barred from thinking about or acting on?

Ms. STEPTOE. Barred from acting on or even thinking about as in: Why would you even bother thinking about it if you can't act on it?

Obviously there are current suggestions that McCarran-Ferguson be repealed. The most I can tell you is the Commission is on record as being opposed to antitrust exemptions. But I can't really get into the details of your question, I am sorry.

Mr. GOODLATTE. The Senate Labor Committee has already voted to repeal McCarran-Ferguson as it applies to insurance in the health care field. I noted that in Senator Metzenbaum's comments. I am not sure I agree with Senator Metzenbaum's approach here

at all, but nonetheless, assuming that took place, would you then go back and create some kind of an exception for this particular field?

Ms. STEPTOE. Well, I think, again, our basic position is that we don't like to create exemptions. But I think if there were a question about whether a particular form of standard setting violated the antitrust law, this is a question we deal with all the time. As you know, standard setting is endemic throughout the whole spectrum of American industry.

There are a lot of standards out there; most have not been challenged by the antitrust enforcers; and that should give you some comfort that a great deal of standard setting is viewed as procompetitive. We look at it, we analyze it under so-called rule of reason. That means we don't come in with the mind set that the conduct is illegal from day one, and we examine the purposes and how it will impact competition. Yes, we could review a standard-setting initiative.

Mr. GOODLATTE. I would view it as very procompetitive in this instance. I think it is good that we have a lot of health insurance companies, not bad, but if it creates inefficiencies that require enormous amounts of paperwork when that could be replaced by modern technology, I think that is something we ought to look at.

Does anybody else on the panel have any comment on this? If not, Mr. Chairman, I have no further questions.

Mr. BROOKS. Mr. Moorhead, the gentleman from California.

Mr. MOORHEAD. Well, thank you, Mr. Chairman.

You know, there has been a lot of comment here about what the effects are going to be on the marketplace. I am more interested in what happens to the patients.

I know one of the problems that the HMO's will not refer outside of their own specialist group, to other practitioners unless they make a special deal with the HMO's at 40 percent of what they would normally charge the person coming in.

I think you already have a potential antitrust violation. What do we have to do to enable a patient that is dying of cancer to be able to go to the City of Hope or to UCLA, neither one of which are getting the HMO referrals?

What do you do when a child whose life is in danger isn't referred to the children's hospitals from an HMO? They won't refer them except in rare circumstances. You have a system where you may not be violating antitrust laws, but you are sure coming close, because part of the provider market isn't available to people. Senior citizens sign up for HMO's because they think it will be cheaper for them. When they really need something and their life is on the line, they are dependent on whoever is there.

I know there are a lot of excellent HMO's. I am not attacking them. Don't get the wrong idea. But I don't think people are able to get the kind of health care they need today in California and other parts of the country. And I think that if we go to the Clinton plan, they are going to be worse off than they are now.

What about hospitals? You may have five hospitals in town, or in the area, but not enough business in each and every specialty for the hospital to have all the specialized equipment without very definitely raising the cost of health care.

I wonder if we couldn't change the antitrust laws so at least the nonprofit hospitals can be able to say, "Look, we are going to specialize in heart care, and you specialize in oncology," and we will do it that way and be able to give people the top-quality care that they need. But they can't collectively agree to divide the functions in that way, without violating antitrust laws. What can we do to make some changes in these areas?

I know what is happening out there because I have heard testimony in the Commerce Committee. I know that it is extremely difficult to get a referral to the best people from the HMO's. I know one lady who is a senior citizen and needs a hip replacement. She belongs to an HMO. And yet they won't refer her to the best specialist in town because he won't reduce his fees to 40 percent of what a person normally pays when they walk in. Isn't this locking up the market? Who wants to take that on?

Mr. O'NEIL-WHITE. I am compelled to take that one on, Congressman Moorhead.

First of all, let me say that study after study after study has demonstrated that the quality of health care received within HMO's is as good or better than the care received in the fee-for-service world. I first take issue with your premise that HMO's don't provide quality health care.

Mr. MOORHEAD. Can you keep up with the City of Hope or UCLA or the children's hospitals?

Mr. O'NEIL-WHITE. I don't have the specifics on those particular services, but HMO's in many of our communities have contracts with a number of those, quote, "high-quality centers" that you mentioned.

I will give you a specific example that there is something called Mayo Choice offered by Health Partners HMO in Minnesota. It has a direct contract with the Mayo Clinic which allows its members to opt out to the Mayo Clinic.

Many of our plans have contracts, have relationships with academic medical centers, other centers of excellence throughout the medical community.

I would point out another thing to you, that compared to the fee-for-service sector, the HMO community, physicians in the HMO community, 80 percent of them, more than 80 percent of them are board certified, compared to 60 percent in the fee-for-service world. So if you are going to make comparisons, I think you will find the quality of care—

Mr. MOORHEAD. What I am saying—if a person's life is on line, there ought to be some way they can get a referral from their HMO to a person who they think can save their life.

Mr. O'NEIL-WHITE. The other point I want to make is that the majority of our HMO's have a product called point-of-service product which allows its members to opt out of the system to do just what you are suggesting. They basically opt into the fee-for-service world and they can select any physician that they want to.

In addition to that, many of the HMO's have contracts with their networks, most of the providers in any given community. Those are nonexclusive networks. The providers can move in and out. The consumers within HMO's do have a wide, wide choice of physicians and other providers.

Mr. MOORHEAD. But the problem with that is that you let them opt out at that point where it is obvious they are going to need a lot of medical care, and you thereby get rid of someone that is going to be using your services an awful lot. You are going to be losing money on them at that point, the point at which they have cancer or AIDS or whatever. You would like to get rid of them, but it may be too late for them to get into another insurance program at that point. You have got to take care of them some way or another.

Mr. O'NEIL-WHITE. Right. Congressman, I agree that we have to take care of them, and what I am suggesting to you is that we do, and we do a very good job at that. What you may be suggesting is that we basically eliminate the concept of HMO's, and the result is a return to the fee-for-service system, and I don't think the consumers out there want that.

One of the—the heart of the concept of managed care and HMO's is the ability to selectively contract, use its leverage in the marketplace to secure quality health care at affordable rates for its enrollees, and to eliminate that ability on the part of HMO's I think cuts the heart out of the whole concept.

Mr. MOORHEAD. I think we need more flexibility in the system. If you go to a PPO, they pay the whole cost of that expense. If you are referred to somebody else, you pay 20 percent of the cost. I think that HMO's often provide wonderful service, maybe 90 or 95 percent of the time. But I do think there are instances where you don't have a specialist in every single area. HMO's have some wonderful, dedicated people. I know they do. I am not putting them down. But there are instances where you need the flexibility to refer somebody outside, in order to save the person's life. Not every doctor that is board certified has that technique that can save someone's life. No one can do everything.

If you are dying or you have got something where you need to be referred, there ought to be some way you can be referred out of the HMO for that problem. If the HMO didn't take care of it, maybe they would pay 80 percent, that is OK. But there has got to be some kind of greater flexibility than we have got now.

Mr. FISH. Will the gentleman yield? Are you waiting for an answer?

Mr. MOORHEAD. I don't seem to be getting one very fast.

Mr. O'NEIL-WHITE. I thought I had answered your question, Congressman Moorhead. I think we do have that flexibility within our system. That is a point I will go back to, that if you look across the country, if you look across the whole HMO and managed care spectrum, we do provide quality health care that is as good or better than we are finding in the fee-for-service world.

And I go back to the point that I just made, that we do have point-of-service products, we have expansive networks that include centers of excellence, clinics like the Mayo Clinic, the Cleveland Clinic.

Mr. MOORHEAD. There are some HMO's that have contracts with some of the better institutions. I agree with you on that. I am talking about what the situation is across the board.

If you knew you were going to have to have a hip replacement and you knew that the orthopedic man in your organization did

about three a year, and you knew that the top guy in town did several hundred of them, and they were successful, I don't think you would go to the guy that did a handful of them. You would want to put your future in the hands of someone you had confidence in. I think you would. And I know I would.

Mr. FISH. If I could just have 30 seconds, Mr. Chairman, I want to thank this panel. I think it has been a very helpful, very instructive morning. But there is one issue we didn't have testimony on, that I want to mention briefly. That is section 5501 of H.R. 3600, which says that the McCarran-Ferguson Act shall not apply to the business of insurance to the extent such business relates to the provision of health benefits. It does not say health policy. It says "health benefits."

And the problem, therefore, is that this language is not limited to health insurance policies. The bill would repeal immunity for all insurer activities that relate to the provision of health benefits. For example, automobile insurance and homeowners' policies that include medical health benefit features would be affected.

I think this is something for us to be conscious of, because the chairman of this committee has come forward with his McCarran proposal, which is inconsistent with the approach taken in H.R. 3600.

I want to thank the witnesses very much.

Mr. BROOKS. To my distinguished friend, we had hearings on McCarran-Ferguson last year, and the same people would be involved in this. I believe we have just about resolved the differences in McCarran-Ferguson. We are looking for an opportunity to get the subcommittee together, and the full committee. I think that most of the players now realize the realities of the situation. I think we will pass the McCarran-Ferguson amendments that we have proposed in the very near future.

I would now like to thank the witnesses for their informative testimony.

For a century, the antitrust laws have stood as a bulwark of free enterprise, not only against anticompetitive conduct in the marketplace, but against those who would seek to institute rigid price controls and other more pervasive regulatory forms of consumer protection. We should think very carefully before enacting legislation that would start us down the road toward more regulation and less competition.

In our effort to bring the soaring costs of health care under control, we should be wary of tampering with the one tried-and-true method of cost containment—vigorous competition under the antitrust laws.

The subcommittee will meet on June 22 to consider medical malpractice issues, another fascinating subject in the Health Security Act.

The hearing is adjourned. Thank you.

[Whereupon, at 12:15 p.m., the subcommittee adjourned, to reconvene subject to call of the chairman.]

APPENDICES

APPENDIX 1.—MATERIAL SUBMITTED WITH THE STATEMENT OF MARY LOU STEPTOE, ACTING DIRECTOR, BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION

FTC news

Federal Trade Commission Washington, D.C. 20580 (202) 326-2180

EMBARGOED UNTIL 10:30 A.M. (EASTERN), SEPTEMBER 15, 1993

FEDERAL TRADE COMMISSION, JUSTICE DEPARTMENT ANNOUNCE JOINT POLICIES FOR HEALTH-CARE ANTITRUST ENFORCEMENT

In an effort to clarify how the nation's two federal antitrust agencies enforce laws governing mergers, joint ventures and other joint activities in the health care industry, the Federal Trade Commission and the Department of Justice today announced six policy statements containing "safety zones" for conduct the agencies generally will not challenge under the antitrust laws.

In addition to the new policy statements, the FTC and the Justice Department said they will respond within 90 days to requests for advice from businesses about topics covered by the statements, and within 120 days to requests for advice regarding other non-merger health care matters. This commitment to swift review will help reduce antitrust uncertainty during a time of "fundamental and far-reaching change" in the health care industry, according to an introduction to the policy statements.

"Antitrust enforcement has historically played an important role in protecting competition in health care markets and lowering the cost of health care for consumers," said FTC Chairman Janet D. Steiger in announcing the policies and in highlighting the FTC's role in that effort. She added, however, that the complexity of antitrust law as it applies to health care "has given rise to the need for greater clarity...so that legitimate conduct is not deterred by unwarranted fears of antitrust prosecution.... These safety zones confirm what the agencies' previous enforcement records bear out: that the covered activities normally do not pose a threat to competition or consumers."

The policy statements embody the longstanding practice of both agencies to challenge only that conduct that is likely to suppress competition and cause consumer harm, and several examples are included to illustrate this. According to the introduction, "inclusion of certain conduct within the safety zones does not imply that conduct falling outside the safety zones is likely to be challenged by the agencies." The statements include an outline of the analysis that the agencies will apply in reviewing conduct which falls outside the safety zones.

(Health Care Policy--09/15/93)

Under the statements, except in extraordinary circumstances, the agencies will not challenge:

1. Hospital mergers where one hospital has fewer than 100 beds, has fewer than 40 patients a day, and is more than five years old. The agencies noted that they have challenged just eight of the more than 200 hospital mergers that have taken place in the United States since 1987.
2. Joint ventures among hospitals to purchase, operate and market high-technology or other expensive medical equipment, that involve only the number of hospitals necessary to support the equipment. If more than the minimum number of hospitals are included in the venture, but the additional hospitals could not support the equipment on their own or through a competing joint venture, the agencies will not challenge the venture. Neither the FTC nor Justice has ever challenged a joint venture among hospitals to purchase, operate and market high-tech or other expensive medical equipment, the agencies noted.
3. The collective provision by physicians of medical information to help purchasers of their services resolve issues about the mode, quality or efficiency of medical treatment. Thus, the agencies would not object to a medical society collecting outcome data from its members about a particular procedure and then providing that information to purchasers. Nor would they challenge the development of suggested standards for clinical patient care by physicians. This safety zone does not protect physician conduct to coerce compliance with recommendations and does not cover the collective provision of fee-related information to purchasers.
4. Participation by competing hospitals in surveys of prices for hospital services, or salaries, wages or benefits of hospital personnel, under certain conditions designed to ensure the data is not used to coordinate prices or costs. To satisfy these conditions, the survey must be managed by a legitimate third-party; the data hospitals provide must be more than three months old; and at least five hospitals must report the data on which each statistic is based. No one hospital's data can represent more than 25 percent of the statistic, and the survey results must be sufficiently aggregated to make it impossible to determine the prices or compensation for any particular hospital.
5. Joint purchasing arrangements among health care providers, as long as they meet conditions designed to ensure they do not become vehicles for collusive purchasing or for price fixing. To fall within this safety zone, the purchases made by the health care providers must account for less than 35 percent of the total market for the purchased items; and for joint purchasing arrangements including direct competitors, the cost of the purchased items must

(Health Care Policy--09/15/93)

account for less than 20 percent of the total revenues of each purchaser.

6. Physician network joint ventures comprised of no more than 20 percent of the physicians in any specialty in a geographic market who have active hospital staff privileges and who share substantial financial risk. The agencies note that ventures falling outside the safety zone still may pass muster under the antitrust laws under various circumstances. In these cases, the ventures will be analyzed by a weighing of their competitive risks and benefits.

The Commission vote to approve the new policy statements was 4-1, with Commissioner Deborah K. Owen dissenting. In dissenting from the Commission's action, Commissioner Owen noted that some of these Policy Statements "retreat from our vigorous enforcement stance of recent years, and particularly from the 1992 Horizontal Merger Guidelines, in several respects. This raises the specter of less energetic prosecution of certain anticompetitive activity in this industry, thereby posing a serious question of harm to some consumers in an area where they are gravely concerned about prices, quality, and availability of services. Some of today's action effectively constitutes a special-interest antitrust exemption that should more appropriately be accomplished through legislative action, if at all, and poses a serious question of unfairness. Other industries, including those experiencing similar, dynamic changes, will not be blessed with the same relief, nor with the availability of expedited advisory opinion mechanisms, no matter how justified their need." [Footnote omitted.]

Copies of the health care antitrust policies are available from the FTC's Public Reference Branch, Room 130, 6th Street and Pennsylvania Avenue, N.W., Washington, D.C. 20580; 202-326-2222; TTY for the hearing impaired 202-326-2502.

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(FTC File No. P859910)
(health)



Department of Justice

FOR IMMEDIATE RELEASE
WEDNESDAY, SEPTEMBER 15, 1993

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ANTITRUST ENFORCEMENT POLICY STATEMENTS
ISSUED FOR HEALTH CARE INDUSTRY

WASHINGTON, D.C. -- First Lady Hillary Rodham Clinton, Attorney General Janet Reno and Anne K. Bingaman, Assistant Attorney General for the Antitrust Division, were joined by Federal Trade Commission Chairman Janet D. Steiger and prominent members of Congress at the Department of Justice to announce steps to make health care more available and affordable to all Americans.

The Department of Justice and the Federal Trade Commission issued six antitrust enforcement policy statements to provide guidance to hospitals and health care providers to know whether they can enter into mergers and joint ventures without violating the antitrust laws. The policy statements will help alleviate uncertainty within the health care industry making it easier for mergers and joint ventures to take place, resulting in lower health care costs.

Assistant Attorney General Anne K. Bingaman said, "Many health care providers have delayed cooperative cost-cutting arrangements because of uncertainty about antitrust restrictions.

I wholeheartedly believe that these new policies will bring down costs to health care consumers while providing effective quality health care services."

The policy statements provide antitrust safety zones which describe circumstances under which the Department of Justice and the Federal Trade Commission will not challenge:

- Hospital mergers;

- Hospital joint ventures involving high-technology or other expensive medical equipment;

- Physicians' provision of information to purchasers of health care services;

- Hospital participation in exchanges of price and cost information;

- Joint purchasing arrangements among health care providers;

- Physician network joint ventures.

The Department of Justice and Federal Trade Commission are also committing themselves to an expedited business review procedure under which the agencies would provide responses within 90 days, after all necessary information is received, to requestors seeking guidance on health care joint ventures and information exchanges.

Today's announcement is part of the Administration's efforts to reform the nation's health care system. The Justice Department is also currently evaluating measures which may increase federal power to combat fraud and abuse. For example,

strengthening anti-kickback laws and making the heavy penalties against defrauding the government applicable to those who defraud the private health care system, as well.

Senator Howard Metzenbaum (D-OH) and Representative Jack Brooks (D-TX) took part in the announcement at the Department of Justice.

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93-271

**DEPARTMENT OF JUSTICE AND FTC
ANTITRUST ENFORCEMENT POLICY STATEMENTS
IN THE HEALTH CARE AREA**

The Department of Justice and the FTC today issued six statements of their antitrust enforcement policies regarding mergers and other joint activities among health care providers.

The six statements address: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) joint purchasing arrangements among health care providers; and (6) physician network joint ventures.

The statements are designed to provide information to the health care community in a time of tremendous change, and to resolve, as completely as possible, any antitrust uncertainty that might deter beneficial mergers or joint ventures that promise to reduce health care costs. Sound antitrust enforcement will not impede efficient transactions, but it will continue to protect consumers against truly anticompetitive activities that lead to higher prices.

Antitrust analysis is inherently fact-intensive. The six policy statements give health care providers guidance, in the form of "antitrust safety zones," which describe the circumstances under which the Agencies will not challenge conduct under the antitrust laws. The statements also summarize the analysis the Agencies will use to review conduct which falls outside the antitrust safety zones.

Providers who wish to have the Agencies' views on specific joint activities that they plan to undertake may obtain a timely response through the Department's expedited business review procedure or the FTC's advisory opinion procedure for the health care community. In the policy statements, the Agencies commit to respond to requests within 90 days after all necessary information is received regarding any matter addressed in the statements except hospital mergers outside the antitrust safety zone. The Agencies make this commitment to swift and certain expedited review in an effort to reduce antitrust uncertainty for the health care industry in a time of fundamental and far-reaching change. The Agencies also recognize that, in light of such change, additional antitrust guidance may be desirable in the areas covered by these policy statements, as well as in other evolving health care contexts. Consequently, the Agencies will issue additional policy statements as warranted.

HOSPITAL MERGERS

The Agencies have challenged only eight of well over 200 hospital mergers in the last five years. Many hospital mergers do not present antitrust concerns because the merging hospitals are not significant competitors of each other. In other cases, where a merger substantially reduced the number of competing hospitals in an area, the Agencies in the past have refrained from bringing an action because the merger produced significant cost savings that could not otherwise be realized.

The policy statement establishes an antitrust safety zone for mergers where one of the merging hospitals is small. Specifically, the Agencies commit not to challenge, absent extraordinary circumstances, a merger in which one of the merging hospitals has

less than 100 licensed beds and an average daily inpatient census of less than 40 patients. This antitrust safety zone will be especially helpful for small rural hospitals, who consider a merger necessary in order to continue providing services, but who fear the cost of an expensive investigation by federal antitrust authorities.

Hospitals which are unsure if they are within the safety zone may obtain timely advice from the Agencies through the expedited 90-day review procedure set forth in the policy statement.

HOSPITAL JOINT VENTURES INVOLVING HIGH-TECHNOLOGY OR OTHER EQUIPMENT

The Agencies have never challenged a joint venture among hospitals to purchase or operate high-technology or other expensive medical equipment. In most cases, these collaborative activities create procompetitive efficiencies that benefit consumers, which outweigh any potential anticompetitive harm. Although numerous hospitals presently participate in joint ventures, it has been suggested that fear of antitrust enforcement currently chills such ventures and forces hospitals to purchase expensive equipment individually, even though joint ventures clearly would be more efficient and less expensive.

The policy statement sets out an antitrust safety zone for joint ventures involving high-technology or other expensive equipment that must be shared in order to allow the hospitals to recover the cost of acquiring, operating and marketing the services provided by the equipment. As long as the joint venture is reasonably necessary to recover these costs and does not include a hospital or a group of hospitals that could have offered a

competing service to the planned joint venture, the Agencies will not challenge, absent extraordinary circumstances, the formation or operation of the venture. For example, joint ventures among rural hospitals to share MRIs or other expensive equipment and agreements among community hospitals to operate helicopter or other expensive services jointly normally will fall within the antitrust safety zone.

Joint ventures that fall outside the antitrust safety zone do not necessarily raise significant antitrust concerns. The policy statement, therefore, includes a brief description and examples of how these ventures will be analyzed. Hospitals considering joint ventures may obtain timely advice from the Agencies through the expedited 90-day review procedure set forth in the policy statement.

PHYSICIANS' PROVISION OF INFORMATION TO PURCHASERS OF HEALTH CARE SERVICES

This policy statement defines an antitrust safety zone that covers the collective provision of non-price information by physicians to purchasers of health care services. The collective provision of this type of information will have procompetitive benefits and allow physicians to work with health care purchasers to improve the quality of care that patients receive. The policy statements provide that the Agencies will not challenge, absent extraordinary circumstances, the collective provision of underlying medical data, including the development of suggested practice parameters.

The safety zone would not cover physicians who collectively threaten to or actually refuse to deal with a purchaser because they object to the purchaser's administrative, clinical or other terms governing the provision of services. In addition, it does not cover

the collective provision of fee-related information. The collective provision of price information is not, however, necessarily illegal. Physicians who wish collectively to provide such information may receive timely advice from the Agencies under the expedited 90-day review procedure.

HOSPITAL PARTICIPATION IN EXCHANGES OF PRICE AND COST INFORMATION

This policy statement defines an antitrust safety zone that covers hospital participation in written surveys of prices for hospital services or wages, salaries or benefits of hospital personnel. The safety zone applies where (1) the survey is managed by a third party, (2) the information collected for the survey is more than three months old, and (3) the price or cost data reported are based on data from at least five hospitals and aggregated so that the prices charged or compensation paid by particular hospitals cannot be identified.

The policy statement also includes a description of how the Agencies will evaluate information exchanges that fall outside the antitrust safety zone. Hospitals that are unsure of the legality of a proposed survey can obtain timely advice from the Agencies through the expedited 90-day review procedure set forth in the policy statement.

JOINT PURCHASING ARRANGEMENTS AMONG HEALTH CARE PROVIDERS

Most joint purchasing arrangements among hospitals or other health care providers do not raise antitrust concerns; indeed the Agencies have never challenged such a joint purchasing arrangement. Such collaborative activities typically allow the participants to

achieve efficiencies that will benefit consumers. This policy statement covers arrangements among providers to purchase such goods and services as laundry or food services, computer or data processing services, and prescription drug and other pharmaceutical products.

Under the policy statement, the Agencies will not challenge, absent extraordinary circumstances, a joint purchasing arrangement if the group's purchases account for less than 35 percent of the total purchases of the relevant product or service, and the cost of the product or service being jointly purchased accounts for less than 20 percent of the total revenues from all products or services sold by each participant in the joint purchasing arrangement.

PHYSICIAN NETWORK JOINT VENTURES

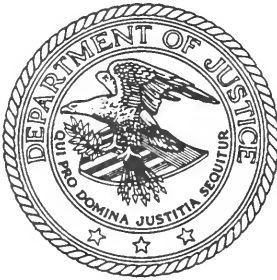
This policy statement sets forth the Agencies' analysis of the formation of physician network joint ventures that are controlled by physicians and that jointly market the services of their member physicians. These joint arrangements have the potential to provide quality services at reduced costs, and can offer significant procompetitive benefits for consumers. Physicians who participate in legitimate network joint ventures can collectively provide information to health care purchasers, and jointly negotiate with them.

The policy statement sets forth an antitrust safety zone that covers physician network joint ventures comprised of 20 percent or less of the physicians in each physician specialty in the relevant geographic market, when the members share substantial financial

risk. The statement includes examples of physician network joint ventures that would meet the requirement of sharing substantial financial risk.

The statement also includes a brief description and examples to illustrate how the Agencies will analyze a physician network joint venture that does not fall within the antitrust safety zone. Physicians forming network joint ventures can obtain timely antitrust advice from the Agencies under the expedited 90-day review procedure.

Statements of Antitrust Enforcement Policy in the Health Care Area



Issued by the
U.S. Department of Justice
and the
Federal Trade Commission

September 15, 1993

**DEPARTMENT OF JUSTICE AND FEDERAL TRADE
COMMISSION ANTITRUST ENFORCEMENT POLICY
STATEMENTS IN THE HEALTH CARE AREA**

The Department of Justice and the Federal Trade Commission (the "Agencies") set forth below six statements of their antitrust enforcement policies regarding mergers and various joint activities in the health care area. The six policy statements address: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) joint purchasing arrangements among health care providers; and (6) physician network joint ventures.

These policy statements are designed to provide education and instruction to the health care community in a time of tremendous change, and to resolve, as completely as possible, the problem of antitrust uncertainty that some have said may deter mergers or joint ventures that would lower health care costs. Sound antitrust enforcement will continue to protect consumers against truly anticompetitive activities.

Antitrust analysis is inherently fact-intensive. The following policy statements give health care providers guidance in the form of "antitrust safety zones," which describe the circumstances under which the Agencies will not challenge

conduct as violative of the antitrust laws as a matter of prosecutorial discretion. The inclusion of certain conduct within the antitrust safety zones does not imply that conduct falling outside the safety zones is likely to be challenged by the Agencies. The statements set forth an outline of the analysis the Agencies will use to review conduct which falls outside the antitrust safety zones.¹

The policy statements also set forth the Department's expedited business review procedure and the Federal Trade Commission's advisory opinion procedure under which the health care community can obtain the Agencies' antitrust enforcement intentions. The policy statements, for the first time, commit the Agencies to responding to requests for business reviews or advisory opinions from the health care community no later than 90 days after all necessary information is received regarding any matter addressed in the statements, except requests relating to hospital mergers outside the antitrust safety zone. The Agencies also will respond to business review or advisory opinion requests regarding other non-merger health care matters within 120 days after all necessary information is received. The Agencies intend to work closely with persons making requests to clarify what information is necessary and to provide guidance throughout the process. The Agencies make this commitment to

¹ These policy statements are intended to describe the Agencies' analysis of conduct falling outside the antitrust safety zones in understandable terms, not to deviate from applicable law or policy statements.

swift and certain expedited review in an effort to reduce antitrust uncertainty for the health care industry in what the Agencies recognize is a time of fundamental and far-reaching change.

The Agencies also recognize that, in light of such change, additional antitrust guidance may be desirable in the areas covered by these policy statements as well as in other evolving health care contexts. Consequently, the Agencies will issue additional policy statements as warranted.

1. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL
TRADE COMMISSION ENFORCEMENT POLICY
ON MERGERS AMONG HOSPITALS

Introduction

Most hospital mergers and acquisitions ("mergers") do not present competitive concerns. While careful analysis may be necessary to determine the likely competitive effect of a particular hospital merger, the competitive effect of many hospital mergers is relatively easy to assess. This statement sets forth an antitrust safety zone for certain mergers in light of the Agencies' extensive experience analyzing hospital mergers. Mergers that fall within the antitrust safety zone will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.² This policy statement also briefly describes the Agencies' antitrust analysis of hospital mergers that fall outside the antitrust safety zone.

A. *Antitrust Safety Zone: Mergers Of Hospitals That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies*

The Agencies will not challenge any merger between two general acute-care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most

² The Agencies are confident that conduct falling within the antitrust safety zones contained in these six policy statements is very unlikely to raise competitive concerns. Accordingly, the Agencies anticipate that extraordinary circumstances warranting a challenge to such conduct will be rare.

recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the three most recent years, absent extraordinary circumstances. This antitrust safety zone will not apply if that hospital is less than 5 years old.

The Agencies recognize that in some cases a general acute care hospital with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients will be the only hospital in a relevant market. As such, the hospital does not compete in any significant way with other hospitals. Accordingly, mergers involving such hospitals are unlikely to reduce competition substantially.

The Agencies also recognize that many general acute care hospitals, especially rural hospitals, with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients are unlikely to achieve the efficiencies that larger hospitals enjoy. Some of those cost-saving efficiencies may be realized, however, through a merger with another hospital.

**B. The Agencies' Analysis Of Hospital Mergers
That Fall Outside The Antitrust Safety Zone**

Hospital mergers that fall outside the antitrust safety zone are not necessarily anticompetitive, and may be procompetitive. The Agencies' analysis of hospital mergers follows the five steps set forth in the Department of Justice-Federal Trade Commission 1992 Horizontal Merger Guidelines.

Applying the analytical framework of the Merger Guidelines to particular facts of specific hospital mergers, the Agencies often have concluded that an investigated hospital merger will not result in a substantial lessening of competition in situations where market concentration might otherwise raise an inference of anticompetitive effects. Such situations include transactions where the Agencies found that: (1) the merger would not increase the likelihood of the exercise of market power either because of the existence post-merger of strong competitors or because the merging hospitals were sufficiently differentiated; (2) the merger would allow the hospitals to realize significant cost savings that could not otherwise be realized; or (3) the merger would eliminate a hospital that likely would fail with its assets exiting the market.

Antitrust challenges to hospital mergers are relatively rare. Of the more than 200 hospital mergers in the United States since 1987, the Agencies have challenged only eight, and in several cases sought relief only as to part of the transaction. Most reviews of hospital mergers conducted by the Agencies are concluded within one month.

* * *

If hospitals are considering mergers that appear to fall within the antitrust safety zone and believe they need additional certainty regarding the legality of their conduct under the antitrust laws, they can take advantage of the Department's business review procedure (28 C.F.R. § 50.6 (1992)) or the Federal Trade Commission's advisory opinion procedure (16

C.F.R. §§ 1.1-1.4 (1993)). The Agencies will respond to business review or advisory opinion requests on behalf of hospitals considering mergers that appear to fall within the antitrust safety zone within 90 days after all necessary information is submitted.

**2. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL
TRADE COMMISSION ENFORCEMENT POLICY
ON HOSPITAL JOINT VENTURES INVOLVING HIGH-
TECHNOLOGY OR OTHER EXPENSIVE MEDICAL EQUIPMENT**

Introduction

Most hospital joint ventures to purchase, operate, and market the services of high-technology or other expensive medical equipment do not create antitrust problems. In most cases, these collaborative activities create procompetitive efficiencies that benefit consumers. These efficiencies include the provision of services at a lower cost or the provision of a service that would not have been provided absent the joint venture. Sound antitrust enforcement policy distinguishes those joint ventures that on balance benefit the public from those that may increase costs without providing a countervailing benefit, and seeks to prevent only those that are harmful to consumers. The Agencies have never challenged a joint venture among hospitals to purchase, operate and market high-technology or other expensive medical equipment.

This statement of enforcement policy sets forth an antitrust safety zone that describes hospital high-technology or other expensive medical equipment joint ventures that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws. It also describes the Agencies' antitrust analysis of hospital high-technology joint ventures that fall outside the antitrust safety zone. Finally, this statement includes examples of its application to hospital high-technology joint ventures.

A. *Antitrust Safety Zone: Hospital High-Technology Joint Ventures That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies*

The Agencies will not challenge under the antitrust laws any joint venture among hospitals to purchase, operate, and market the services of high-technology or other expensive medical equipment if the joint venture includes only the number of hospitals whose participation is needed to support the equipment, absent extraordinary circumstances.³ A joint venture that includes additional hospitals also will not be challenged if the additional hospitals could not support the equipment on their own or through the formation of a competing joint venture, absent extraordinary circumstances.

For example, if two hospitals are each unlikely to be able to recover the cost of individually purchasing, operating and marketing the services of a magnetic resonance imager (MRI) over its useful life, their joint venture with respect to the MRI would not be challenged by the Agencies. On the other hand, if the same two hospitals entered into a joint venture with a third hospital that independently could have purchased, operated, and marketed an MRI in a financially viable manner, the joint venture would not be in this antitrust safety zone. If,

³ A hospital or group of hospitals will be considered able to support high-technology or other expensive medical equipment for purposes of this antitrust safety zone if it could recover the acquiring, operating, and marketing costs of the equipment over its useful life. If the joint venture is limited to purchasing, only the acquiring costs are relevant. If the joint venture is limited to purchasing and operating, only the acquiring and operating costs are relevant.

however, none of the three hospitals could have supported an MRI by itself, the Agencies would not challenge the joint venture.⁴

Information necessary to determine whether the costs of a piece of high-technology medical equipment could be recovered over its useful life is normally available to any hospital or group of hospitals considering such a purchase. This information may include the cost of the equipment, its expected useful life, the minimum number of procedures that must be done to meet a machine's financial breakeven point, the expected number of procedures the equipment will be used for given the population served by the joint venture and the expected price to be charged for the use of the equipment. Expected prices and costs should be confirmed by objective evidence, such as experiences in similar markets for similar technologies.

B. The Agencies' Analysis of Hospital High-Technology Or Other Expensive Medical Equipment Joint Ventures That Fall Outside the Antitrust Safety Zone

The Agencies recognize that joint ventures that fall outside the antitrust safety zone do not necessarily raise significant antitrust concerns. The Agencies will apply a "rule of reason"

⁴ The antitrust safety zone described in this statement applies only to the joint venture and agreements reasonably necessary to the venture. It would not apply to or protect, for example, agreements made by participants in a joint venture that are related to a service not provided by the venture.

analysis in their antitrust review of such joint ventures.⁵ The objective of this analysis is to determine whether the joint venture may reduce competition substantially, and if it might, whether it is likely to produce procompetitive efficiencies that outweigh its anticompetitive potential. This analysis is flexible and takes into account the nature and effect of the joint venture, the characteristics of the services involved and of the hospital industry generally, and the reason for, and purposes of, the venture. It also allows for consideration of efficiencies that will result from the venture. The steps involved in a rule of reason analysis are set forth below.⁶

Step One: Define The Relevant Market. The rule of reason analysis first identifies the service that is produced through the joint venture. The relevant product and geographic markets that include the service are then properly defined. This process seeks to identify any other provider that could offer a service that patients or physicians generally would consider a good substitute to that provided by the joint venture. Thus, if a joint venture were to purchase and jointly operate and market

⁵ This statement assumes that the joint venture is not likely merely to restrict competition and decrease output. For example, two hospitals that independently operate profitable MRI services could not avoid charges of price fixing by labelling as a joint venture their plan to obtain higher prices through joint marketing of their existing MRI services.

⁶ For many joint ventures, it will be clear initially that the likelihood of competitive harm is small or that the venture will provide substantial efficiencies. In such cases, it will not be necessary to complete all steps in the analysis to conclude that the joint venture should not be challenged.

the services of an MRI, the relevant market would include all other MRIs in the area that could feasibly serve the same patients, but would not include providers with only traditional X-ray equipment.

Step Two: Evaluate The Competitive Effects Of The Venture. This step begins with an analysis of the structure of the relevant market. If there are many providers that would compete with the joint venture, it is unlikely that competitive harm would result from the joint venture in the relevant market and the analysis would continue with step four described below.

If the structural analysis of the relevant market determined that the joint venture would eliminate an existing or potentially viable competing provider of a service and that there were few other competing providers of that service, it then would be necessary to assess the extent of the potential anticompetitive effects of the joint venture. In addition to the number of competing providers, other factors that could restrain the ability of the joint venture to raise prices either unilaterally or through collusive agreements with other providers would include: (1) regulatory restraints on price; (2) characteristics of the market that make anticompetitive agreements unlikely; and (3) the likelihood that others would enter the market and start providing the service.

The extent to which the joint venture restricts competition among or between the hospitals participating in the venture is evaluated during this step. In some cases, a joint venture to purchase high-technology equipment may not substantially

eliminate competition between the hospitals in providing the service made possible by the equipment. For example, two hospitals might purchase a mobile MRI jointly, but operate and market MRI services separately. In such instances, the potential impact on competition of the joint venture would be substantially reduced.⁷

Step Three: Evaluate The Impact Of Procompetitive Efficiencies. This step requires an examination of the venture's potential to create procompetitive efficiencies, and the balancing of these efficiencies against any potential anticompetitive effects. In the case of high-technology medical equipment, efficiencies can be substantial because of the need to spread the cost of expensive equipment over a large number of patients and the potential for improvements in quality to occur as providers gain experience and skill from performing a larger number of procedures.

Step Four: Evaluate Ancillary Agreements. This step determines whether the joint venture includes ancillary agreements or conditions that unreasonably restrict competition and are unlikely to contribute significantly to the legitimate purposes of the joint venture. For example, if the participants in a joint venture formed to purchase a mobile lithotripter also were to agree on the daily room rate to be charged lithotripsy patients who required overnight hospitalization, this ancillary

⁷ If steps one and two reveal no competitive concerns with the joint venture, step three is unnecessary, and the analysis continues with step four described below.

agreement as to room rates would be unnecessary to achieve the benefits of the lithotripter joint venture. Although the joint venture itself would be legal, the ancillary agreement on hospital room rates would not be legal and would be challenged.

C. Examples of Hospital High-Technology Joint Ventures

The following are examples of hospital joint ventures that are unlikely to raise significant antitrust concerns. Each is intended to demonstrate an aspect of the analysis that would be used to evaluate the venture.

1. New Service That Can Be Offered Only By A Joint Venture

All the hospitals in a relevant market agree that they jointly will purchase, operate and market a helicopter to provide emergency transportation for patients. The need for helicopter services is not great enough to justify having more than one helicopter operating in the area and studies of similarly sized communities indicate that a second helicopter service could not be supported.

This joint venture falls within the antitrust safety zone. It would make available a service that would not otherwise be available, and for which duplication would be inefficient.

2. Joint Venture to Purchase Expensive Equipment

All five hospitals in a relevant market jointly agree to purchase a mobile lithotripter. Each will share equally in the

cost of maintaining the equipment, and the equipment will travel from one hospital to another and be available one day each week at each hospital. The hospitals' agreement contains no provisions for joint marketing of, and protects against exchanges of competitively sensitive information regarding, lithotripsy services.⁸ There are also no limitations on the prices that each hospital will charge for lithotripsy services, on the number of procedures that each hospital can perform, or on each hospital's ability to purchase a lithotripter of its own. Although any combination of two of the hospitals could afford to purchase the equipment and recover their costs within the equipment's useful life, patient volume from all five hospitals is required to maximize the efficient use of the machine and lead to significant cost savings. In addition, patient demand would be satisfied by provision of the equipment one day each week at each hospital. The joint venture would result in higher use of the equipment, thus lowering the cost per patient and potentially improving quality.

This joint venture does not fall within the antitrust safety zone because smaller groups of hospitals could afford to purchase and operate lithotripters and recover their costs. Therefore, the joint venture would be analyzed under the rule of reason. The relevant service would be lithotripsy services, and the five hospitals all potentially compete against each other

⁸ Examples of such information include prices and marketing plans.

for patients requiring this service. Although there are other procedures, such as surgery, that can be used to treat some patients, this example assumes that these procedures are not included in the relevant market because patients who receive lithotripsy services are unlikely to switch to other treatments in response to a price increase in lithotripsy services.

Because the joint venture is likely to reduce the number of lithotripters in the market, there is a potential restraint on competition. The restraint would not be substantial, however, for several reasons. First, the joint venture is limited to the purchase of the equipment and would not eliminate competition among the hospitals in the provision of lithotripsy services. Each hospital will market its services independently, and will not exchange competitively sensitive information. In addition, the venture does not preclude a hospital from purchasing another unit should the demand for these services increase. Because the joint venture raises some competitive concerns, however, it is necessary to examine the potential efficiencies created by the venture. The joint venture would produce substantial efficiencies while providing access to high quality care. Thus, this joint venture would on balance benefit consumers since it would not lessen competition substantially, and it would allow the hospitals to provide a service in a more efficient manner. On these facts, the joint venture would not be challenged by the Agencies.

* * *

Hospitals that are considering high-technology or other expensive equipment joint ventures and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department's expedited business review procedure for joint ventures and information exchanges announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of a hospital high-technology joint venture within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

**3. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL
TRADE COMMISSION ENFORCEMENT POLICY
ON PHYSICIANS' PROVISION OF INFORMATION TO
PURCHASERS OF HEALTH CARE SERVICES**

Introduction

The collective provision of information by competing physicians to a purchaser in an effort to influence the terms upon which the purchaser deals with the physicians does not necessarily raise antitrust concerns. Generally, physicians' collective provision of certain types of information to a purchaser is likely either to provide procompetitive benefits or to raise little risk of anticompetitive effects.

This statement sets forth an antitrust safety zone that describes collective physician provision of information that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.⁹ It also describes conduct that is expressly excluded from the antitrust safety zone.

A. *Antitrust Safety Zone:* Physicians' Collective Provision Of Information That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

Physicians' collective provision of underlying medical data that may improve purchasers' resolution of issues relating to

⁹ This statement is limited to physicians' collective activities. Physicians acting individually may provide any information to any purchaser without incurring liability under federal antitrust law. Moreover, this statement is limited to the collective provision of information outside the scope of a joint venture. The exchange of information that necessarily occurs among physicians involved in joint venture activities generally does not raise antitrust concerns.

the mode, quality, or efficiency of treatment is unlikely to raise any significant antitrust concern and will not be challenged by the Agencies, absent extraordinary circumstances. Thus, the Agencies will not challenge, absent extraordinary circumstances, a medical society's collection of outcome data from its members about a particular procedure that they believe should be covered by a purchaser and the provision of such information to the purchaser. The Agencies also will not challenge, absent extraordinary circumstances, physicians' development of suggested practice parameters--standards for patient management developed to assist physicians in clinical decisionmaking--which also may provide useful information to patients, physicians, and purchasers. Because physicians' collective provision of such information poses little risk of restraining competition and may help in the development of protocols that increase quality and efficiency, the Agencies will not challenge such activity, absent extraordinary circumstances.

Excluded from the antitrust safety zone is any attempt by physicians to coerce a purchaser's decisionmaking by implying or threatening a boycott of any plan that does not follow the physicians' joint recommendation. Physicians who collectively threaten to or actually refuse to deal with a purchaser because they object to the purchaser's administrative, clinical, or other terms governing the provision of services run a substantial antitrust risk. For example, physicians' collective refusal to provide X-rays to a purchaser that seeks them before

covering a particular treatment regimen would present an antitrust violation. Similarly, physicians' collective attempt to force purchasers to adopt recommended practice parameters by threatening to or actually boycotting purchasers that refuse to accept their joint recommendation also would risk antitrust challenge.

The antitrust safety zone set forth in this policy statement does not extend to physicians' collective provision of fee-related information to purchasers. Such conduct can raise antitrust concerns to the extent it signals or facilitates physicians' collective price demands. Competing physicians who seek to negotiate fees that they would like to be paid with a purchaser run a substantial antitrust risk, and an even greater risk if they implicitly or explicitly threaten to boycott or actually boycott a purchaser that does not accept their "suggested" fees. Depending on the circumstances, however, the provision of fee-related information can be useful to purchasers, who may seek such information for procompetitive purposes.

* * *

Competing physicians who are considering jointly providing information to a purchaser and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a

business review or advisory opinion request on behalf of physicians who are considering jointly providing information within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

**4. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL
TRADE COMMISSION ENFORCEMENT POLICY
ON HOSPITAL PARTICIPATION IN EXCHANGES OF
PRICE AND COST INFORMATION**

Introduction

Participation by competing hospitals in surveys of prices for hospital services, or surveys of salaries, wages or benefits of hospital personnel, does not necessarily raise antitrust concerns. In fact, such surveys can have significant benefits for health care consumers. Hospitals can use information derived from price and compensation surveys to price their services more competitively and to offer compensation that attracts highly qualified personnel. Purchasers also can use price survey information to make more informed decisions when buying hospital services. Without appropriate safeguards, however, information exchanges among competing hospitals may facilitate collusion or otherwise reduce competition on prices or compensation, resulting in increased prices, or reduced quality and availability of hospital services. A collusive restriction on the compensation paid to hospital employees, for example, could create personnel shortages that would adversely affect the availability of health care services.

This statement sets forth an antitrust safety zone that describes exchanges of price and cost information among hospitals that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances. It also briefly describes the Agencies' antitrust analysis of

information exchanges that fall outside the antitrust safety zone.

A. *Antitrust Safety Zone: Exchanges Of Price And Cost Information Among Hospitals That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies*

The Agencies will not challenge, absent extraordinary circumstances, hospital participation in written surveys of (a) prices for hospital services,¹⁰ or (b) wages, salaries or benefits of hospital personnel, if the following conditions are satisfied:

- (1) the survey is managed by a third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association);
- (2) the information provided by survey participants is based on data more than 3 months old; and
- (3) there are at least five hospitals reporting data upon which each disseminated statistic is based, no individual hospital's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular hospital.

The conditions that must be met for an information exchange among hospitals to fall within the antitrust safety zone are intended to ensure that an exchange of price or cost data is not used by competing hospitals for discussion or coordination of

¹⁰ The "prices" at which hospitals offer their services to purchasers can take many forms, including billed charges for individual services, discounts off billed charges, or per diem, capitated, or diagnosis related group rates.

hospital prices or costs. They represent a careful balancing between a hospital's individual interest in obtaining information useful in adjusting the prices it charges or the wages it pays in response to changing market conditions against the risk that the exchange of such information may permit competing hospitals to communicate with each other regarding a mutually acceptable level of prices for hospital services or compensation for employees.

B. The Agencies' Analysis Of Hospital Exchanges Of Information That Fall Outside The Antitrust Safety Zone

Exchanges of price and cost information that fall outside the antitrust safety zone generally will be evaluated to determine whether the information exchange may have an anticompetitive effect that outweighs any procompetitive justification for the exchange. Depending on the circumstances, public, non-provider initiated surveys may not raise competitive concerns. Such surveys could allow purchasers to have useful information that they can use for procompetitive purposes.

Exchanges of future prices for hospital services or future compensation of employees are very likely to be considered anticompetitive. If an exchange among competing hospitals of price or cost information results in an agreement among competitors as to the prices for hospital services or the wages to be paid to hospital employees, that agreement will be considered unlawful per se.

* * *

Competing hospitals that are considering participating in a survey of price or cost data and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department's expedited business review procedure announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of hospitals who are considering exchanging information within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

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**5. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL
TRADE COMMISSION ENFORCEMENT POLICY
ON JOINT PURCHASING ARRANGEMENTS
AMONG HEALTH CARE PROVIDERS**

Introduction

Most joint purchasing arrangements among hospitals or other health care providers do not raise antitrust concerns. Such collaborative activities typically allow the participants to achieve efficiencies that will benefit consumers. Joint purchasing arrangements usually involve the purchase of a product or service used in providing the ultimate package of health care services or products sold by the participants. Examples include the purchase of laundry or food services by hospitals, the purchase of computer or data processing services by hospitals or other groups of providers, and the purchase of prescription drugs and other pharmaceutical products. Through such joint purchasing arrangements, the participants frequently can obtain volume discounts, reduce transaction costs, and have access to consulting advice that may not be available to each participant on its own.

Joint purchasing arrangements are unlikely to raise antitrust concerns unless (1) the arrangement accounts for so large a portion of the purchases of a product or service that it can effectively exercise market power¹¹ in the purchase of

¹¹ In the case of a purchaser, this is the power to drive down the price of goods or services being purchased below competitive levels.

the product or service, or (2) the products or services being purchased jointly account for so large a proportion of the total cost of the services being sold by the participants that the joint purchasing arrangement may facilitate price fixing or otherwise reduce competition. If neither factor is present, the joint purchasing arrangement will not present competitive concerns.¹²

This statement sets forth an antitrust safety zone that describes joint purchasing arrangements among health care providers that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws. It also describes factors that mitigate any competitive concerns with joint purchasing arrangements that fall outside the antitrust safety zone.¹³

¹² An agreement among purchasers that simply fixes the price that each purchaser will pay or offer to pay for a product or service is not a legitimate joint purchasing arrangement and is a per se antitrust violation. Legitimate joint purchasing arrangements provide some integration of purchasing functions to achieve efficiencies.

¹³ This statement applies to purchasing arrangements through which the participants acquire products or services for their own use, not arrangements in which the participants are jointly investing in equipment or providing a service. Joint ventures involving investment in equipment and the common provision of services are discussed in a separate policy statement.

**A. *Antitrust Safety Zone: Joint Purchasing Arrangements
Among Health Care Providers That Will Not Be Challenged,
Absent Extraordinary Circumstances, By The Agencies***

The Agencies will not challenge, absent extraordinary circumstances, any joint purchasing arrangement among health care providers where two conditions are present: (1) the purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and (2) the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement.

The first condition compares the purchases accounted for by a joint purchasing arrangement to the total purchases of the purchased product or service in the relevant market. Its purpose is to determine whether the joint purchasing arrangement might be able to drive down the price of the product or service being purchased below competitive levels. For example, a joint purchasing arrangement may account for all or most of the purchases of laundry services by hospitals in a particular market, but represent less than 35 percent of the purchases of all commercial laundry services in that market. Unless there are special costs that cannot be easily recovered associated with providing laundry services to hospitals, such a purchasing arrangement is not likely to force prices below competitive levels. The same principle applies to joint purchasing arrangements for food services, data processing, and many other products and services.

The second condition addresses any possibility that a joint purchasing arrangement might result in standardized costs, thus facilitating price fixing or otherwise having anticompetitive effects. This condition applies only where some or all of the participants are direct competitors. For example, if a nationwide purchasing cooperative limits its membership to one hospital in each geographic area, there is not likely to be any concern about reduction of competition among its members. Even where a purchasing arrangement's membership includes hospitals or other health care providers that compete with one another, the arrangement is not likely to facilitate collusion if the goods and services being purchased jointly account for a small fraction of the final price of the services provided by the participants. In the health care field, it may be difficult to determine the specific final service in which the jointly purchased products are used, as well as the price at which that final service is sold.¹⁴ Therefore, the Agencies will examine whether the cost of the products or services being purchased jointly accounts, in the aggregate, for less than 20 percent of the total revenues from all health care services of each competing participant.

¹⁴ This especially is true because some large payers negotiate prices with hospitals and other providers that encompass a group of services, while others pay separately for each service.

B. Factors Mitigating Competitive Concerns With Joint Purchasing Arrangements That Fall Outside The Antitrust Safety Zone

Joint purchasing arrangements among hospitals or other health care providers that fall outside the antitrust safety zone do not necessarily raise antitrust concerns. There are several safeguards that joint purchasing arrangements can adopt to mitigate concerns that might otherwise arise. First, antitrust concern is lessened if members are not required to use the arrangement for all their purchases of a particular product or service. Members can, however, be asked to commit to purchase a voluntarily specified amount through the arrangement so that a volume discount or other favorable contract can be negotiated. Second, where negotiations are conducted on behalf of the joint purchasing arrangement by an independent employee or agent who is not also an employee of a participant, antitrust risk is lowered. Third, the likelihood of anticompetitive communications is lessened where communications between the purchasing group and each individual participant are kept confidential, and not discussed with, or disseminated to, other participants.

These safeguards will reduce substantially, if not completely eliminate, use of the purchasing arrangement as a vehicle for discussing and coordinating the prices of health care services offered by the participants.¹⁵ The adoption of

¹⁵ Obviously, if the members of a legitimate purchasing group engage in price fixing or other collusive anticompetitive conduct as to services sold by the participants, whether through the arrangement or independently, they remain fully subject to antitrust challenge.

these safeguards also will help demonstrate that the joint purchasing arrangement is intended to achieve economic efficiencies rather than to serve an anticompetitive purpose. Where there appear to be significant efficiencies from a joint purchasing arrangement, the Agencies will not challenge the arrangement absent substantial risk of anticompetitive effects.

The existence of a large number and variety of purchasing groups in the health care field suggests that entry barriers to forming new groups currently are not great. Thus, in most circumstances at present, it is not necessary to open a joint purchasing arrangement to all competitors in the market. The exclusion from the arrangement of some competitors will raise antitrust concerns only if those who are excluded are put at a significant competitive disadvantage in competing with the participants.

* * *

Hospitals or other health care providers that are considering joint purchasing arrangements and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure for joint ventures and information exchanges announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of a health care provider joint purchasing arrangement within 90 days after all necessary information is submitted. The Department's

December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

**6. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL
TRADE COMMISSION ENFORCEMENT POLICY
ON PHYSICIAN NETWORK JOINT VENTURES**

Introduction

In recent years, many independent physicians and physician groups have organized independent practice associations ("IPAs"), preferred provider organizations ("PPOs"), and similar physician network joint ventures to market their services to health insurance plans and other purchasers.¹⁶ Typically, such ventures contract to provide physician services to plan subscribers at reduced prices, and commit to utilization review and other limits on the provision of unnecessary care. Because of their potential for providing quality services at reduced costs, IPAs, PPOs, and similar physician network joint ventures promise significant procompetitive benefits for consumers of health care services.¹⁷

This statement of enforcement policy sets forth an antitrust safety zone that describes physician network joint ventures that will not be challenged, absent extraordinary

¹⁶ An IPA or PPO typically provides medical services to the subscribers of health insurance plans, but it does not act as the insurer of the subscribers. In addition, an IPA or PPO does not require complete integration of the medical practices of its member physicians. Such physicians typically continue to compete for patients who are enrolled in health insurance plans not served by the IPA or PPO.

¹⁷ As used in this policy statement, a physician network joint venture is a physician-controlled venture that jointly markets the services of its member physicians. Other types of health care network joint ventures are not addressed by this policy statement.

circumstances, by the Agencies under the antitrust laws.¹⁸ It also describes the Agencies' antitrust analysis of physician network joint ventures that fall outside the antitrust safety zone. Finally, this statement presents examples of its application to physician network joint ventures.

A. *Antitrust Safety Zone: Physician Network Joint Ventures That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies*

The Agencies will not challenge, absent extraordinary circumstances, a physician network joint venture comprised of 20 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market¹⁹ and share substantial financial risk. In relevant markets with less than five physicians in a particular specialty, a physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty even though the inclusion of that physician results in a physician network joint venture consisting of more than 20 percent of the physicians in

¹⁸ Although this statement refers to IPAs and PPOs as examples of physician network joint ventures, the Agencies' competitive analysis focuses on the substance of such arrangements, not on their formal title. This policy statement applies, therefore, to all entities that are substantively equivalent to a physician network joint venture.

¹⁹ Generally, relevant geographic markets for the delivery of physician services are localized.

that specialty.²⁰

To qualify for the antitrust safety zone, physicians participating in a physician network joint venture must share substantial financial risk. The following are examples of situations in which substantial financial risks are shared by members of a physician network joint venture:

- (a) when there is agreement to provide services to a health insurance plan at a "capitated" (or per subscriber) rate; or
- (b) provision by a physician network joint venture of financial incentives for its members to achieve cost-containment goals, such as withholding a substantial amount of the compensation due to its members, with distribution of that amount to members only if cost-containment goals are met.

The antitrust safety zone applies equally to "exclusive" and "non-exclusive" physician network joint ventures. However, the exclusive or non-exclusive nature of a physician network joint venture is important to the rule of reason analysis of ventures falling outside the antitrust safety zone, as discussed below. An "exclusive" venture significantly restricts the ability of its members to affiliate with other physician network joint ventures and to contract individually with health insurance plans. A "non-exclusive" venture, on the other hand, does not impose any significant explicit or implicit restriction

²⁰ For purposes of this antitrust safety zone, in calculating the number of physicians in a relevant market and the number participating in a physician network joint venture, each physician ordinarily will be counted individually, whether the physician practices in a group or solo practice.

on the ability of its members to affiliate or contract with such other organizations.

B. The Agencies' Analysis Of Physician Network Joint Ventures That Fall Outside The Antitrust Safety Zone

Physician network joint ventures that fall outside the antitrust safety zone do not necessarily raise substantial antitrust concerns. Indeed, even joint ventures that contain more than 20 percent of the physicians in a relevant market can be procompetitive. Physician network joint ventures will be reviewed under a rule of reason analysis and not viewed as per se illegal²¹ either if the physicians in the joint venture share substantial financial risk or if the combining of the physicians into a joint venture enables them to offer a new product producing substantial efficiencies. A rule of reason analysis determines whether the joint venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from the joint venture. The rule of reason analysis is flexible, and takes into account all characteristics of the particular physician network joint venture that bear on its likely effect on competition. The steps involved in a rule of reason analysis of physician network joint ventures are set forth below.

²¹ This statement assumes that the joint venture is not likely merely to restrict competition and decrease output, such as, for example, an agreement among physicians that simply fixes the price that each purchaser will pay.

Step one: Define The Relevant Market. The rule of reason analysis first identifies the relevant services that the physician network joint venture provides. Although all services provided by each physician specialty ordinarily will be considered a separate relevant service market, there may be instances in which significant overlap of services provided by different specialties of physicians justifies including physicians from more than one specialty in the same market. For each relevant service market, the relevant geographic market will include all physicians whom health insurance plans and their subscribers consider to be good substitutes for physicians participating in the joint venture.

Step Two: Evaluate The Competitive Effects Of The Physician Joint Venture. The structure and activities of the physician network joint venture and the nature of competition in the relevant market are examined to determine whether the formation or operation of the venture is likely to have an anticompetitive effect. Two key areas of competitive concern are whether a physician network joint venture could raise the prices for physician services charged to health insurance plans above competitive levels or prevent the formation of other physician network joint ventures that would compete with it.

If in the relevant market there are many other physician network joint ventures or many physicians who would be available to form competing physician network joint ventures or be available to contract directly with health insurance plans, it is unlikely that the joint venture would raise any competitive

concerns. In assessing the availability of physicians in the relevant market for forming competing physician network joint ventures, it will be necessary to analyze both the number of physicians in each relevant service market and the competitive significance of the exclusive or non-exclusive nature of the physician network joint venture. If a physician network joint venture is non-exclusive, the anticompetitive risks posed by such a venture may be substantially less than if the participating physicians had formed an exclusive physician network joint venture.²²

Step Three: Evaluate The Impact Of Procompetitive Efficiencies. This step requires an examination of the venture's potential to create procompetitive efficiencies, and the balancing of these efficiencies against any potential anticompetitive effects. The potential of physician network joint ventures to generate efficiencies by lowering the costs of health care to consumers can vary substantially. Efficiencies that the Agencies are most likely to recognize include any cost savings associated with the assumption of financial risk by the participating physicians. The Agencies will also consider other possible efficiencies, such as reduced administrative costs, improved utilization review, improved case management, quality assurance and economies of scale.

²² If steps one and two reveal no competitive concerns with the physician network joint venture, step three is unnecessary, and the analysis continues with step four below.

Step Four: Evaluation Of Ancillary Agreements. This step determines whether the physician network joint venture includes ancillary agreements or conditions that unreasonably restrict competition and are unlikely to contribute significantly to the legitimate purposes of the physician network joint venture. For example, if the physicians participating in a joint venture agree on the prices they will charge patients who are not covered by the health insurance plans with which their joint venture contracts, such an agreement plainly is unnecessary to the success of the joint venture and is an antitrust violation.²³

C. Examples Of Physician Network Joint Ventures That The Agencies Would Not Challenge

The following are examples of physician network joint ventures that are unlikely to raise significant antitrust concerns. Each is intended to demonstrate an aspect of the analysis that would be used to evaluate such ventures under this policy statement.

1. Physician Network Joint Venture Comprising More Than 20 Percent Of Physicians With Active Staff Privileges At A Hospital

County Seat is a relatively isolated, medium-sized community of about 350,000 residents. The closest town is 50 miles away. County Seat has five general acute care

²³ This analysis of ancillary agreements also applies to physician network joint ventures that fall within the antitrust safety zone.

hospitals, which offer a mix of basic primary, secondary, and tertiary care services.

A total of 500 physicians have medical practices based in County Seat, and all maintain active staff privileges at one or more of County Seat's hospitals. No physician from outside County Seat has any type of staff privileges at a County Seat hospital. The physicians represent 10 different specialties and are distributed evenly among the specialties, with 50 doctors practicing each specialty.

One hundred physicians (also distributed evenly among specialties) maintain active staff privileges at County Seat Medical Center. County Seat's other 400 physicians maintain active staff privileges at other County Seat hospitals.

Half of County Seat Medical Center's 100 active staff physicians propose to form an IPA to market their services to purchasers of health care services. The physicians are divided evenly among the specialties. Under the proposed arrangement, the physicians participating in the joint venture would agree to meaningful cost containment and quality goals, including utilization review, quality assurance, and other measures designed to reduce the provision of unnecessary care to the plan's subscribers, and a substantial amount (in this example 20 percent) of the compensation due to member physicians would be withheld and distributed only if these measures are successfully met. This physician network joint venture would be exclusive in that participating physicians would not be free to contract individually with health insurance plans or to join

other physician joint ventures.

A number of health insurance plans that contract selectively with hospitals and physicians already operate in County Seat. These plans as well as local employers agree that other County Seat physicians, and the hospitals to which they admit, are good substitutes for the active staff physicians and the inpatient services provided at County Seat Medical Center. Physicians with medical practices based outside County Seat, however, are not good substitutes for area physicians, because such physicians would find it inconvenient to practice at County Seat hospitals due to the distance between their practice locations and County Seat.

Competitive Analysis

A key issue is whether a physician network joint venture, such as this IPA, comprised of 50 percent of the physicians in each practice specialty with active staff privileges at one of five comparable hospitals in County Seat would fall within the antitrust safety zone. The physicians within the joint venture represent less than 20 percent of all the physicians in each specialty in County Seat.

County Seat is the relevant geographic market for purposes of analyzing the competitive effects of this proposed physician joint venture. Within each specialty, physicians with staff privileges at area hospitals are good substitutes for one another. However, physicians with practices based elsewhere are not considered good substitutes.

For purposes of analyzing the effects of the venture, all of the physicians in County Seat should be considered market participants. Purchasers of health care services consider all physicians within each specialty, and the hospitals at which they have staff privileges, to be relatively interchangeable. Thus, in this example, any attempt by the joint venture's participants collectively to increase the price of physician services above competitive levels would likely lead third-party payers to recruit nonparticipating physicians at County Seat Medical Center or other area hospitals.

Because physician network joint venture participants comprise less than 20 percent of each group of specialists in County Seat and because the physicians agreed to share substantial financial risk, this proposed joint venture would fall within the antitrust safety zone.

2. Physician Network Joint Venture With A Large Market Share In A Relatively Small Community

Smalltown has a population of 25,000, a single hospital, and 50 physicians, most of whom are family practitioners. All the physicians practice exclusively in Smalltown and have active staff privileges at the Smalltown hospital. The closest urban area, Big City, is located some 35 miles away and has a population of 500,000. A little more than half of Smalltown's working adults commute to work in Big City. Some of the health insurance plans used by employers in Big City are interested in extending their network of providers to Smalltown to provide

coverage for subscribers who live in Smalltown, but commute to work in Big City (coverage is to include the families of commuting subscribers). However, the number of commuting Smalltown subscribers is a small fraction of the Big City employers' total workforce.

Responding to these employers' needs, a few health insurance plans have asked physicians in Smalltown to organize a nonexclusive IPA large enough to provide a reasonable choice to subscribers who reside in Smalltown, but commute to work in Big City. Because of the relatively small number of potential enrollees in Smalltown, the plans prefer to contract with such a physician network joint venture, rather than engage in what may prove to be a time-consuming series of negotiations with individual Smalltown physicians to establish a panel of physician providers there.

A number of Smalltown physicians have agreed to form a physician network joint venture. The joint venture will contract with health insurance plans to provide physician services to subscribers of the plans in exchange for a monthly capitation fee paid for each of the plans' subscribers. The physicians forming this joint venture would constitute about half of the total number of physicians in Smalltown. They would represent about 35 percent of the town's family practitioners, but higher percentages of the town's general surgeons (50 percent), pediatricians (50 percent), and obstetricians (67 percent). The health insurance plans that serve Big City employers say that the IPA must have a large percentage of

Smalltown physicians to provide adequate coverage for employees and their families in Smalltown and in a few scattered rural communities in the immediate area and to allow the doctors to provide coverage for each other.

In this example, other health insurance plans already have entered Smalltown, and contracted with individual physicians. They have made substantial inroads with Smalltown employers, signing up a large number of enrollees. None of these plans has had any difficulty contracting with individual physicians, including many who would participate in the proposed joint venture.

Finally, the evidence indicates that Smalltown is the relevant geographic market for all physician services. Physicians in Big City are not good substitutes for a significant number of smalltown residents.

Competitive Analysis

This proposed physician network joint venture would not fall within the antitrust safety zone because it would be comprised of over 20 percent of the physicians in a number of relevant specialties in the geographic market. However, the Agencies would not challenge the joint venture because a rule of reason analysis indicates that its formation would not likely hamper the ability of health insurance plans to contract individually with area physicians or with other physician network joint ventures. In addition, the joint venture is likely to result in cost savings because the physicians have agreed to accept capitated fees.

That health insurance plans have requested formation of this venture also is significant, for it suggests that the joint venture would offer additional efficiencies. In this instance, it appears to be a low-cost method for plans to enter an area without investing in costly negotiations to identify and contract with individual physicians.

Moreover, in small markets such as Smalltown, it may be necessary for purchasers of health care services to contract with a relatively large number of physicians to provide adequate coverage and choice for enrollees. For instance, if there were only three obstetricians in Smalltown, it would not be possible for a physician network joint venture offering obstetrical services to have less than 33 percent of the obstetricians in the relevant area. Furthermore, it may be impractical to have less than 67 percent in the plan, because two obstetricians may be needed in the venture to provide coverage for each other.

Despite the joint venture's relatively large market share of some specialists, it appears unlikely to have anticompetitive effects because of three factors: the demonstrated ability of health insurance plans to contract with physicians individually, if they so desire; the possibility that other physician network joint ventures could be formed; and the benefits that health insurance plans perceive in obtaining the coverage provided by this physician network joint venture. Therefore, the Agencies would not challenge this physician network joint venture.

* * *

Physicians who are considering forming joint ventures and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure for joint ventures and information exchange programs announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of a physician network joint venture within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

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APPENDIX 2.—MATERIAL SUBMITTED FOR THE HEARING RECORD

STATEMENT OF THE
 ALLIANCE OF AMERICAN INSURERS
 AMERICAN COUNCIL OF LIFE INSURANCE
 NATIONAL ASSOCIATION OF INDEPENDENT INSURERS
 NATIONAL ASSOCIATION OF LIFE UNDERWRITERS
 NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES
 NATIONAL ASSOCIATION OF PROFESSIONAL INSURANCE AGENTS
 REINSURANCE ASSOCIATION OF AMERICA
 COALITION FOR A COMPETITIVE INSURANCE MARKET
 BEFORE THE
 HOUSE JUDICIARY COMMITTEE
 SUBCOMMITTEE ON ECONOMIC & COMMERCIAL LAW
 JUNE 15, 1994
 ON H.R. 3600
 THE ADMINISTRATION'S HEALTH CARE PLAN PROPOSAL
 TO REPEAL THE MCCARRAN-FERGUSON ACT (Section 5501)

H.R. 3600, the Administration's health care plan, contains a provision which would repeal the McCarran-Ferguson federal antitrust exemption for a large part of the business of insurance. Insurance industry trade associations representing the bulk of the industry oppose this provision and remain steadfast in support of the McCarran Act because it has helped foster a competitive insurance market for insurance consumers around the country.

Joining in this statement are the following trade organizations: the Alliance of American Insurers, the American Council of Life Insurance, the National Association of Independent Insurers, the National Association of Life Underwriters, the National Association of Mutual Insurance Companies, the National Association of Professional Insurance Agents, the Reinsurance Association of America, and the Coalition for a Competitive Insurance Market.

All of us are very concerned about rising costs in the health care delivery system, but the McCarran Act has nothing to do with this problem. The truth is, the McCarran Act is working well and doesn't need "fixing." The Administration's proposal could actually make matters worse.

We also believe it is inappropriate to make drastic changes to the country's antitrust laws in the context of dealing with problems in the health care delivery system.

The Administration's health care plan would repeal the McCarran-Ferguson antitrust exemption for the business of insurance "to the extent that such business relates to the provision of health benefits."

The intent of the Administration, as set out in summaries of the proposal, is to repeal McCarran for health insurers. However, the effect of the actual legislative language extends far beyond health insurers. The unintended consequence of this provision amounts to "backdoor" repeal of

the McCarran Act for property/casualty insurers and for life insurers selling health insurance as well.

Property/casualty insurers generally bear liability for health care costs where an insured is legally responsible for an injury to another person. Often property/casualty insurers are primarily responsible for providing such health benefits. The following property/casualty lines of insurance would be affected by the Administration's proposal because those policies provide for health benefits: workers compensation, personal auto, commercial auto, general liability and products liability, medical malpractice, commercial multi-peril, homeowners and farmowners.

Approximately \$29 billion, or 20%, of the property/casualty insurance industry's incurred losses were attributable to health care costs in 1992, according to the Insurance Services Office. So, the property/casualty insurance industry would be significantly affected by this proposal. Life insurers and agents would be affected to the extent that it would be impossible to separate their health and life insurance activities in home offices and agency offices as well.

The McCarran-Ferguson Act promotes competition and is essential for a healthy, competitive marketplace. Insurers are jointly involved in many vital and pro-consumer practices, permitted under McCarran and subject to state oversight and regulation. These activities include data collection to assist in ratemaking, packaging insurance products and pooling arrangements for hard to place risks. Depriving insurance companies of the benefits of McCarran in such instances would stifle innovation, decrease competition and increase consumers' insurance costs.

Costly litigation over the meaning and application of this provision can also be expected. The provision also contemplates dual federal-state regulation of the industry and the unnecessary expense that will entail to the industry and consumers. There are also numerous practical problems and questions about implementation which need to be examined.

Last July, NAI testified against the H.R. 9 McCarran repealer bill on behalf of seven major insurance industry trade associations representing the bulk of the insurance industry. We understand that another industry trade association, the American Insurance Association, has worked with the Chairman to develop a so-called "compromise" McCarran repealer, which we also oppose for a variety of reasons.

Conceptually, a McCarran repealer bill with so-called "safe harbors" is doomed to failure. It is simply impossible to itemize all of the current and future essential industry activities which need to be preserved. In any listing, there are bound to be some items left out. Also, ambiguous language will provide for inadequate protection.

The proposed "compromise" vividly demonstrates the problems with such an approach. The "safe harbors" do not provide complete protection for trending. This will have a devastating impact on small and medium sized companies, competition and consumers. Small and medium sized companies rely heavily on trended data to help them compete against the giants, and many of them will have great difficulty remaining in the market without it. This will mean less competition

and will be harmful to consumers who will have fewer choices in the market and will face higher prices.

Manuals of rules and supplementary rating information are also not protected, but they promote competition and their absence will cause chaos in the marketplace for agents and consumers.

Where safe harbors are provided in the so-called "compromise," they are often inadequate. For example, the language covering such vital areas as historical data, policy forms, inspection and fire protection is inadequate, as ISO has fully demonstrated.

The proposal purports to reaffirm the availability of the state action doctrine, but in reality it is a step backward from current law and will raise more questions than it answers.

Massive amounts of litigation can be expected over the meaning and the scope of the "safe harbors," if this bill becomes law. In fact, we believe the proposal will create a "litigation machine."

Finally, the proposal calls for dual federal/state regulation of insurance. The bill provides for expanded authority for the Department of Justice and the Federal Trade Commission. The result will mean unnecessary added costs for companies, agents and consumers, with no demonstrated benefits.

All of these proposals to repeal the McCarran Act--Section 5501 of the Administration's health care plan, H.R. 9 and the so-called "compromise"-- should be rejected because they are unnecessary, they will destroy the current competitive insurance marketplace and they will harm consumers.



AMERICAN
COLLEGE OF
NURSE-MIDWIVES

PREPARED STATEMENT
OF THE
AMERICAN COLLEGE OF NURSE-MIDWIVES

SUBMITTED TO
HOUSE JUDICIARY SUBCOMMITTEE ON ECONOMIC
AND COMMERCIAL LAW
UNITED STATES HOUSE OF REPRESENTATIVES

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HEARING ON HR 3600 "HEALTH SECURITY ACT"

--ANTITRUST ISSUES

JUNE 15, 1994

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The American College of Nurse-Midwives ("ACNM") has consistently opposed any antitrust exemption in connection with health care reform. ACNM opposes those aspects of section 1322(c) of S. 1757 (Health Security Act) which immunize the federal antitrust laws provider conduct which would otherwise violate section one of the Sherman Act (15 U.S.C. § 1). The provisions of this section of the bill would permit health care providers to discuss and agree upon prices and fees, and then to negotiate those fees collectively with health alliances for purposes of developing fee-for-service fee schedules. In effect, this exemption would permit groups of health providers to fix prices for their services -- not only with regard to the fee-for-service schedules but, as a result of spillover effects, in connection with negotiations with health plans.

ACNM also opposes S. 1658 and S. 1770, bills which would carve out broad and unnecessary antitrust exemptions for various types of joint conduct among health care providers. ACNM believes that the Statements of Antitrust Enforcement Policy in the Health Care Area, which were issued by the U.S. Department of Justice Antitrust Division and the Federal Trade Commission on September 15, 1993, provide sufficient guidance to health professionals and institutions that wish to avoid the risk of antitrust liability. The broad immunities created by these bills are unnecessary and potentially harmful, not only to consumers but also to health professionals such as certified nurse-midwives ("CNMs") who compete with members of dominant provider groups.

In this Statement, we will address each of these bills separately.

HR 3600 (Health Security Act). Much of our specific concern about the exemption contained in this bill is based upon its failure to provide any real supervision or control over provider conduct during the process of fee-setting and negotiation. The term "negotiations" is defined in this bill broadly enough to encompass and shelter otherwise blatant price fixing activity and will provide an opportunity for competitor collusion on fees. Legally-permitted opportunities for fee-related collusion are highly likely to spill over into and taint areas where such competitor price fixing is not permitted, such as provider negotiations with health plans. Allowing competitors who have not integrated into provider networks to nevertheless exchange fee information and agree upon fee levels which will be sought from the alliances can only have the inevitable effect of increasing the risk that this information will be used in other, still-prohibited contexts.

This exemption is derived from the existing "state action" antitrust exemption, a court-created immunity which has protected the actions of State governmental agencies, as well as private individuals and entities who act in reliance on, or in obedience to, such state policies, from the federal antitrust laws. Historically, the courts have only permitted such immunity to the extent that conduct which would otherwise violate the antitrust laws is the result of a comprehensive, clearly articulated, and affirmatively expressed state policy to replace competition with regulation for a particular sector of the State's economy. Additionally, the state policy must provide for active supervision of the private conduct by a branch of state government which has enforcement power to detect and prevent abuses. These safeguards are intended to protect consumers.

This section of the bill also extends the Noerr-Pennington doctrine, an exemption which protects lobbying and other efforts to influence governmental decision-making from antitrust enforcement, to provider groups that negotiate with alliances.

Another serious problem with this section is that the statute's formulation of these exemptions is not as explicitly or as carefully worded as the tests which the United States Supreme Court has developed with respect to these exemptions and does provide for state government supervision. Thus, not only does section 1322 extend what was formerly a narrowly-construed exemption to conduct which would otherwise be considered per se illegal, but it does so in a manner far less rigorous than the courts have employed when ruling upon state-developed exemptions and immunities in this and other industries.

ACNM opposes the antitrust exemption provisions of this bill because it undermines a key original intention of health care reform – to create alliances of business and consumers that could use their combined buying power to keep health care costs down. Joint provider negotiations, however, would permit physicians and other large groups of providers to counter whatever buying power the alliances may have. This is, in fact, the argument raised in favor of this exemption by its supporters, but it would change the balance of power. While this change might improve the financial prospects of providers under health care reform it would be highly detrimental to consumers' pocketbooks.

ACNM is aware that the proposed exemption would apply to all categories and groups of health care providers, not just physicians and hospitals and, thus, would supposedly benefit its own members by permitting CNMs to negotiate with the alliances over fees. Thus, superficially, it might appear that CNMs would also be entitled to set fees among themselves, to negotiate fee schedules with alliances and, ultimately, to derive the spillover benefit from those negotiations into their dealings with health plans. As a practical matter, however, ACNM's members are only too aware that the provision offers no real negotiation rights for groups of non-MD providers. CNMs and other non-physicians, who have far less any market power than physicians, would most likely be effectively disregarded or shut out of negotiations with alliances while organized groups of physicians dominate the negotiation process.

Finally, the proposed exemption is unnecessary. To the extent that any state wishes to permit negotiations between alliances and providers, it can craft a statute which would satisfy existing "state action" immunity standards which because they require state government supervision, will also protect consumer interest. Section 1322 (c) should be deleted from the HSA. Any state that wishes to avail itself of state action immunity standards may do so.

S. 1658 and S. 1770. ACNM opposes the antitrust exemptions and immunities which would be created by these bills. These proposed exemptions are far more extensive than either existing antitrust defenses and immunities (which are equally available) to other sectors of the U.S. economy or the Department of Justice/FTC Enforcement Policy Statements. Based upon ACNM's consultation with FTC and DOJ officials and upon observation of the applicability of the Statements in practice over the past several months, ACNM is satisfied that the Enforcement Policy Statements can be refined into a useful tool which will be equally applicable to non-physicians. These Statements will provide sufficient guidance to discourage genuine antitrust violations and abuses while permitting procompetitive joint actions by health professionals and other providers.

ACNM is greatly concerned that the provisions of these bills will leave its members largely defenseless against the anticompetitive practices of dominant provider groups. Nurse-midwives, like many other groups of non-MD health professionals, have indeed looked upon the antitrust laws as the "Magna Carta of our free enterprise system." For many years, CNMs have sought the assistance and protection of the Federal Trade Commission and the federal courts when anticompetitive barriers to nurse-midwifery practice were unjustifiably imposed by

hospitals, by groups of physicians, by health insurance plans, or by malpractice insurers. Mary Lou Steptoe, Acting Director of the FTC's Bureau of Competition, cited one such example in her testimony -- a boycott of nurse-midwives and the physician who worked with them by a malpractice insurer controlled by the state medical society [State Volunteer Mutual Insurance Co., 103 F.T.C. 1232 (1983)], but many other examples exist. Many other malpractice insurers, similarly controlled by state medical societies or other groups of physicians, routinely impose excessive and unjustified surcharges upon obstetricians who work or consult with nurse-midwives. One such case occurred in the District of Columbia only two years ago.

In addition, nurse-midwives are frequently denied access to clinical privileges to provide their professional services in hospitals, even when the hospital administration affirmatively desires to add CNMs to its staff, because of organized opposition by the hospital's medical staff. The FTC has filed at least one such action to open up a hospital medical staff over physician collusive opposition [In re Medical Staff of Memorial Medical Center (File No. 851-0002), 5 Trade Reg. Rep. ¶ 22,508 (January 28, 1988)], and individual nurse-midwives have filed private antitrust actions to overcome organized physician resistance to hospital access by CNMs. One such case, Nurse-Midwifery Associates v. Habet, 918 F.2d 605 (6th Cir. 1990), held that physician members of medical staff may be held liable for conspiring with each other as independent competitors, to commit an antitrust violation by excluding a competing health professional.

Nurse-midwives today confront numerous other instances of anticompetitive conduct designed to exclude them from competing in the health care market. The preservation of federal antitrust laws is essential to provide remedies for antitrust violations which injure our members' ability to practice and deny consumer's any choice among health professionals. Denial of clinical privileges is widespread. In addition, many health insurance companies or managed care plans, particularly if they are controlled by a physician-dominated provider panel or by the state medical society, routinely refuse to reimburse for CNM services or to permit CNMs to become members of the provider panel of an IPA or PPO. Such exclusion of a competing non-MD provider was held, in Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1980), to be a violation of section one of the Sherman Act. Unfortunately, ACNM can provide numerous instances where a managed care plan has refused to include CNMs on it's panel because of physician opposition, with the result that CNM practices have gone out of business while women and infants in the area remain underserved.

ACNM is also concerned about the development of practice guidelines or parameters by physician groups, under the guise of quality of care standard setting, which are really thinly-disguised attempts to limit the scope of nurse-midwifery practice or to discourage physicians, hospitals, or managed care plans from working with CNMs. Anticompetitive standard-setting is not uncommon in health care or other markets. See, e.g. American Society of Mechanical Engineers C. Hydrolevel Corporation 456 U.S. 556 (1982) (product quality standards developed by professional society which are used to injure competitor of member violate antitrust laws). Groups of physicians may develop "standards" or "practice parameters" which contrary to state scope of practice laws for CNMs, or clinical indicators, limit particular procedures to physicians or would require physician supervision of CNMs. ACNM is greatly concerned that blanket antitrust exemptions, of the breadth demonstrated in these two bills, will condone and permit such practice barriers and other means of anticompetitive exclusion of nurse-midwives while, at the same time, limiting the range and effectiveness of antitrust remedies available to those whose business or property has been injured by reason of these or other antitrust violations. The FTC and Antitrust Division cannot rectify or monitor all anticompetitive activities. ACNM's members and the consumers they serve would be greatly harmed if the remedy of treble damages lawsuits to vindicate practice restrictions were eliminated or rendered impractical.

Attached to our testimony is a copy of an advertisement opposing antitrust exemptions which appeared in the Wall Street Journal this past week. ACNM, along with several other consumer and provider groups, is a signatory to that advertisement. The American Medical Association has accused the insurance industry of using consumer and non-M.D. provider groups to cloak an anti-physician insurer agenda. ACNM is not a pawn of the insurance industry by any means, and opposes continued antitrust exemption for the insurance industry under the McCarran-Ferguson Act. Antitrust exemptions should play no role whatsoever in health care reform. Rather, to the extent that market forces are being encouraged, through various proposed health reform plans, to lower costs and make insurance accessible to all Americans, antitrust exemptions can only be counterproductive to such goals. ACNM will continue its opposition to all such special interest legislation.

The ACNM has adopted this position because its leadership and members believe that such exemptions are contrary to the spirit and the principles of health care reform, injurious to consumer welfare and, ultimately, unnecessary. We also believe that all anticompetitive activities, whether monopolistic practices by insurers or providers, competitor collusion, or discrimination by physicians, hospitals, and health plans against non-MD health professionals, will ultimately result in restricting optimal delivery of health care services, limiting consumer choice, and injuring those who provide, as well as those who purchase, such services. We urge committee members to consider the important consumer protection and competition values which are at stake in this legislation and to reject any and all antitrust exemptions for health care providers or other participants in the health care industry.

JUST SAY "NO" TO THE A.M.A.

The Honorable Howard M. Metzenbaum
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

As Congress considers health care reform legislation, we are writing to express our opposition to the creation of statutory antitrust exemptions, such as those proposed in the President's "Health Security Act" and in S. 1658/H.R. 3486, the "Health Care Antitrust Improvements Act of 1993". These exemptions would inhibit competition and harm consumers by increasing costs and impeding innovation in health care delivery.

Current antitrust laws are intended to preserve competition and promote consumer welfare. As such, these laws are crucial to achieving two critical goals of health care reform: 1) to provide consumers with affordable, high-quality care and 2) to promote the efficient delivery of services.

Expanding antitrust exemptions beyond what current law permits, would only serve to undermine these objectives by insulating collusive activities. Ultimately, the public could bear the brunt of these changes in the form of:

• HIGHER PRICES

Antitrust laws prevent price-fixing and the potential boycotting of health plans while promoting competitively priced fees that lower health costs. Last year, FTC Chair Janet D. Steiger testified that "experience from the Commission's health care enforcement program suggests that antitrust

enforcement plays an important role in preventing organized efforts to reduce price competition and thwart cost reductions."

• REDUCED QUALITY AND CHOICE

If physicians are allowed to engage in otherwise prohibited collaborations, they could act to restrict the type and categories of providers available to patients. In addition, sanctioning limited competition among certain providers could reduce their incentive to improve quality of care and service.

• LESS INNOVATION

Existing antitrust law provides adequate flexibility for physicians, hospitals and professional groups to work together to organize new networks and other provider delivery systems. More importantly, they help promote innovation by encouraging providers to distinguish themselves in ways that will benefit consumers — for example by competing on the basis of quality as well as cost. New antitrust exemptions would simply halt the competitive incentive for innovation.

While we acknowledge that additional enforcement guidelines may be necessary as the new health system evolves, we also recognize the very real dangers inherent in moving beyond what current law has deemed to be safe, appropriate and necessary. We are thus in complete agreement that changes to existing antitrust laws are simply unnecessary and a real threat to consumer welfare.

Sincerely,

American
Association of
Retired Persons

American
Association of
Nurse Anesthetists

American
Federation of Home
Health Agencies

American College
of Nurse-Midwives

The Alliance
For Managed
Competition

American Nurses
Association

American
Occupational
Therapy
Association

American
Optometric
Association

American Speech-
Language Hearing
Association

Aetna

Consumer
Federation of
America

The ERISA
Industry
Committee

Blue Cross &
Blue Shield
Association

Blue Cross of
California

CIGNA Corporation

National Capital
PPO

Consumers Union
of United States

Federation of
American Health
Systems

Group Health
Association of
America

Home Health
Services & Staffing
Association

Independence Blue
Cross

MetLife

National
Association of
Childbearing
Centers

The Principal
Financial Group

The Prudential

The Travelers
Insurance
Companies

U.S. Healthcare

Washington
Business Group
on Health



American Health Care Association 1201 L Street, NW, Washington, DC 20005-4014

FAX: 202-842-3860

202-842-4444

Writer's Telephone:

Written Testimony of the American Health Care Association
to the
U.S. House Committee on the Judiciary
on
Fraud and Abuse Provisions
in the H.R. 3600

June 15, 1994

Chairman Brooks, Congressman Fish and members of the Committee, the American Health Care Association (AHCA) appreciates the opportunity to provide you with our Association's position on the fraud and abuse provisions contained in the Health Security Act, H.R. 3600. AHCA is a federation of 51 affiliated associations representing 11,000 non-profit and for-profit nursing facilities, residential care, and subacute providers nationwide.

AHCA fully supports efforts to combat fraud and abuse in health care. We have worked with Congress and the Administration on ensuring that quality care is provided to nursing home residents and that compensation be fair and equitable to both the government and to providers. We are continuing efforts to ensure that providers comply with federal law by working with the Health Care Financing Administration to advise our members on what constitutes inappropriate billing practices.

FRAUD AND ABUSE PROVISIONS

We are pleased that the Committee is examining this issue and the proposed changes in fraud and abuse law. Provisions to modify Federal health care fraud and abuse statutes are contained in several health care reform proposals and in the Senate passed Omnibus Anticrime bill (H.R. 3355).

The Health Security Act contains the following provisions.

It creates a new standard for health care fraud as a new federal crime. Such action will be a felony with fines up to \$250,000 and ten years of imprisonment, or life imprisonment if the violation results in serious bodily injury. This would apply to both federally and privately financed health care activities.

If a health care offense poses a serious threat to the health of

any person or has a significant detrimental impact on the health care delivery system there can be imposed criminal forfeiture of property that is used, supported, or added value to the commission of the offense.

Any individual, engaged in a pattern of health care fraud, Food and Drug Administration violations, or anti-kickback violations could be civilly or criminally prosecuted under the Racketeer Influenced and Corrupt Organizations (RICO) statute.

Any individual with certain controlling interest in an entity that has been sanctioned through criminal prosecution, civil money penalties or program exclusion may be excluded from health care programs even if the individual had absolutely no responsibility for the conduct that led to the sanction.

Federal, State and local law enforcement programs will coordinate their efforts to control fraud and abuse by developing joint enforcement programs and sharing information and resources.

Civil monetary penalties and penalties for false claims would be increased. Such penalties will be applied to providers who incorrectly code services or provide medically unnecessary services. This would apply to claims submitted to both Federal and private insurance plans.

Persons, other than beneficiaries who suffer harm or monetary loss as a result of any activity of an individual or entity which would subject that individual to civil monetary penalty, may bring an action against that provider in Federal court.

PROBLEMS AND IMPROVEMENTS TO PROVISIONS

AHCA believes that there are two problems with the aforementioned fraud and abuse proposal. First, it relies solely on enforcement and there is no effort to enhance prevention and compliance. Secondly, it reaches far beyond those who purposefully act with criminal intent.

Improving Compliance

While enforcement is important, many problems such as miscoding or improper billing of services can be remedied through education and guidance by the Federal government. Medicare and Medicaid laws and regulations are extremely complex and it is difficult for providers to determine if they are in compliance. The breadth and lack of clarity of the current fraud and abuse laws has created confusion and uncertainty for providers working to develop innovative, lawful arrangements for the delivery of long term care services. Without clarification, this confusion and uncertainty is likely to increase with the dramatic expansion of the fraud and abuse laws contemplated by numerous legislative proposals.

Currently the U.S. Department of Health and Human Services, Office of the Inspector General is prohibited from providing advisory opinions to health care providers seeking to enter into innovative ways to deliver long term care services. Congressman Hoagland (D-NE) has introduced legislation (H.R.4028) which authorizes the Secretary of Health and Human Services to issue such opinions. This will greatly aid providers in ensuring that they stay in compliance with Federal law when delivering services in a rapidly changing health care delivery system.

Another step that Congress can take is to allow long term care providers to petition the Office of the Inspector General to issue "Fraud Alerts." In the past, the Office of the Inspector General has issued such "Alerts" when it wished to make the industry aware that it considered certain conduct unlawful (or potentially unlawful). Permitting health care providers to request Fraud Alerts regarding contemplated transactions would provide increased clarity concerning the Office of Inspector General's interpretation of the law and would thereby promote compliance.

Ensuring Honest Providers are not Harmed

While AHCA fully supports the intent of the provisions, we are concerned that they would extend beyond those who willfully defraud the government to honest providers who innocently commit an error or disagree with an insurance company's perception of a patient regimen of treatment. Some specific examples are as follows.

Section 4043 would provide civil monetary penalties for miscoding of procedure or diagnosis codes, providing items or services in excess of medical need, or providing services not medically necessary. The practice of medicine is as much an art as a science. A practitioner must deal with many uncertainties, and may try a variety of approaches to diagnose a condition and treat it. In many cases medical necessity is a judgment call and judgment can be influenced whether you are a provider delivering services or a claims reviewer seeking to keep down costs. This provision should be limited to cases where willful intent to commit fraud is demonstrated.

Section 4044 provides for the permissive exclusion of individuals simply because they own shares in a sanctioned entity even if the individual had absolutely no responsibility for the conduct that led to the sanction. The individuals to whom the exclusion authority would apply include anyone with an investment interest of 5% or more, or anyone with management responsibilities, including members of the Board of Directors. As a result, an individual, simply by his or her relationship or status with a company, can be excluded from health care programs, even if the individual had no knowledge of, or responsibility for, the events that lead to the sanction on the company. In fact, the proposal

does not even require that the individual was affiliated with the company at the time the conduct occurred on which the sanction is based. This provision will make it virtually impossible to obtain medical professionals to sit on Boards of Directors of long term care facilities. Clearly, responsibility must be brought back into the determination process.

Conclusion

AHCA supports the effort to ensure compliance with Federal Health care laws. While the effort to ensure greater enforcement is commendable, we must ensure that long term care providers who seek to operate within the law have the proper guidance. In addition, we must ensure that criminal law does not extend to those who have no criminal intent. The provisions must be tightened up to limit their scope to those who willfully violate the law. To that end we will be happy to work with you and your Committee.

American Hospital Association



Capitol Place, Building #3
50 F Street, N.W.
Suite 1100
Washington, D.C. 20001
Telephone 202.638-1100
FAX NO. 202.626-2345

June 16, 1994

The Honorable Jack Brooks
U.S. House of Representatives
2449 Rayburn House Office Building
Washington D.C. 20515-4309

Dear Chairman Brooks:

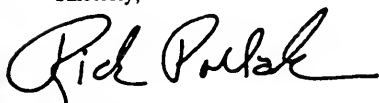
The 5,000 hospital members of the American Hospital Association are strong supporters of health care reform. We support three fundamental goals: universal access and coverage, delivery system restructuring, and fair financing of reform. Because of our strong commitment to these goals, we want to go on record at this time stating our opposition to the creation of statutory antitrust exemptions for physicians such as those proposed in the Health Security Act, President Clinton's proposal (S. 1757 and H.R. 3600), and in the Health Care Quality Improvements Act of 1993, sponsored by Senators Hatch and Thurmond (S. 1658) and Representative Archer (H.R. 3486). These exemptions run counter to the goals of health care reform.

AHA believes that a reformed delivery system should be based on integrated multi-provider networks—we call them community care networks™—providing care at the community level. Achieving this vision requires providers to join together with aligned goals and incentives to provide high quality, affordable care. Statutory exemptions for physicians do not promote integration, facilitate network development, or encourage change in our currently fragmented delivery system.

Such exemptions from the antitrust laws are unnecessary and potentially dangerous. The proposed exemptions would immunize all health care-related activity that certain groups of physicians undertake, even if the activity does not further the quality, efficiency, and access goals of health care reform. Exemptions allowing providers to organize solely to negotiate rates could result in higher, not lower, health care costs to consumers. Providers seeking greater bargaining power or wishing to develop physician-sponsored plans can do so without an antitrust exemption, by integrating to share financial and operational risk. And risk-sharing creates incentives to offer low cost services, and be competitive in health care delivery. In short, such exemptions would impede the development of efficient multi-provider networks.

Rather than advocating the adoption of statutory exemptions, AHA seeks an essential examination and clarification of antitrust policies in order to encourage and facilitate development of integrated multi-provider networks. Joint Department of Justice and Federal Trade Commission guidelines on difficult issues are needed now, specifically with respect to the formation and operation of multi-provider networks, joint provision of services and use of equipment, the role of efficiencies in merger and joint venture analysis, and the "state action" doctrine. But AHA will not support legislative proposals to grant blanket immunity to providers whose activities have no or very limited potential for efficiencies...particularly where exemptions could result in increased health care costs and foster fragmentation of health care delivery. Such measures fly in the face of health care reform.

Sincerely,



Rick Pollack
Executive Vice-President
Federal Relations

Attachment

This letter was sent to:

All members of the Senate Finance Committee
Chairman Kennedy, Senate Labor and Human Resources Committee
Chairman Metzenbaum, Senate Judiciary Committee
Chairman Gibbons, House Ways and Means Committee
Chairman Brooks, House Judiciary Committee

American Hospital Association



840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone: 312.280.6000
Cable Address: AMHOSP

January 28, 1994

Anne K. Bingaman
Assistant Attorney General
Antitrust Division
U.S. Department of Justice
10th & Constitution Ave., N.W.
Room 3101
Washington, D.C. 20503

Dear Assistant Attorney General Bingaman:

The issuance of the Statements of Antitrust Enforcement Policy in the Health Care Area ("Policy Statements") on September 15, 1993 was an important first step toward reducing the uncertainty that many providers are experiencing as the health care field consolidates in anticipation of health care reform. The American Hospital Association ("AHA") applauds the Department of Justice ("Department") and the Federal Trade Commission ("FTC") for recognizing the need for health care-specific guidance. As you have agreed, however, additional guidance is necessary. We are pleased to provide you with our suggestions for such guidance.

In response to economic pressures to control costs, hospitals, physicians and other providers are increasingly engaging in cooperative activity in order to provide services more efficiently. The prospect of national health care reform under a "managed competition" model has also encouraged health care providers to form networks and other collaborative arrangements in preparation for dealing with or becoming health plans. Regardless of whether health care legislation is passed in the near future, economic pressure on providers to merge or form joint ventures will continue. In recognition of the trend toward consolidation in the health care field, the AHA believes more guidance from the Agencies is necessary, particularly with respect to the following topics: 1) network formation and operation; 2) joint ventures involving services or existing equipment; 3) efficiency justifications for mergers and joint ventures; and 4) the state action doctrine.

1) Network Formation and Operation

The formation of integrated networks by hospitals, physicians and other providers is by far the most obvious change in the composition of health care markets in the 1990s. The Department and the FTC repeatedly have identified procompetitive effects in

health care markets due to the formation and operation of provider networks.¹

Networks can take a variety of forms. Some networks involve only specialized services, while others are designed to offer comprehensive services. Some networks are fully integrated, e.g., Kaiser Permanente, with the providers operating within a common legal superstructure, but most networks have been -- and probably will continue to be -- created through a series of contractual arrangements between physicians, hospitals and other providers. While these contractual networks will, themselves, differ significantly from each other, what differentiates them from cartel arrangements is that they all possess some form of partial functional integration, typically taking the form of risk-based pricing, responsibility for utilization review, responsibility for quality assurance or all of the above.

The development of integrated networks, almost by definition, involves increased collaboration among providers. In partially integrated networks, network participants frequently offer jointly derived prices for services and sometimes may agree to reduce unnecessary capacity and duplication in order to achieve significant cost savings. Virtually all networks require the exclusion of some providers, and many also involve exclusive arrangements or the bundling of different services into a single product offering. Effective antitrust policy should articulate

¹ See Policy Statement No. 6 (reduced prices, utilization review and other limits on the provision of unnecessary care); FTC Enforcement Policy Statement Fed. Reg., Vol. 46, No. 192 at 48984 (1981) (hereinafter "FTC Statement") (a plan may create competition among physicians when it limits the panel of physicians); Letter to David A. Gates from Jeffery I. Zuckerman, Director Bureau of Competition, dated November 5, 1986 at 1 and 3 (hereinafter "Zuckerman Letter") (distinguishes products for consumers and stimulates competition); Department Press Release regarding Stanislaus Preferred Provider Organization, Inc., dated October 12, 1983 at 3 (lowering costs); Letter to Robert Taylor from Charles Rule, Acting Assistant Attorney General, dated October 3, 1986 at 2 (increasing competition among providers and improving service); Letter to F. M. Bush III from Charles Rule, Acting Assistant Attorney General, dated April 7, 1987 at 4 (increasing competition among providers, lowering costs and providing consumers alternatives); Remarks of J. Paul McGrath, Assistant Attorney General, before the American Bar Association dated March 22, 1985 at 2-3 (increasing competition, allowing market influences on price and utilization, consumers given alternatives and lowering costs).

which of these arrangements are permissible and which are objectionable, and, as a consequence, likely to be challenged.²

The Need for a Safety Zone for Integrated Networks Involving Hospitals

The sixth Policy Statement establishes a safety zone for certain physician network joint ventures. Many of the networks currently being developed and likely to be encouraged by federal health care policy, however, involve hospitals and other non-physician providers, making a policy statement addressing these networks essential.

Because hospital markets tend to be highly concentrated, the thresholds contained in the physician network safety zone cannot appropriately be applied to fully and partially integrated networks involving hospitals.³ In order to provide guidance to these networks, the Agencies should build upon the physician network policy statement and establish a safety zone that recognizes the many communities in which there are fewer than five hospitals. Indeed, in discussing the safety zone for physician network joint ventures, the Agencies state that "[i]n relevant markets with less than five physicians in a particular specialty, the physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty even though the inclusion of that physician results in a physician network joint venture" beyond the 20% limit of the safety zone.⁴

In analyzing networks, the primary antitrust concern is that the network not obtain and misuse market power. No hospital, or grouping of hospitals, is likely to possess market power⁵ if the

² Our comments are addressed to legitimate networks, those with operational or financial integration.

³ The physician network safety zone limits physician participation to 20%. In many hospital markets, however, the inclusion of a even single hospital is likely to represent more than 20% of hospital service capacity.

⁴ Policy Statement No. 6.

⁵ Market power has been defined as the ability to profitably increase prices above competitive levels. Jefferson Parish Hospital Dist. No. 2 v. Hyde, 466 U.S. 2, 27 n.46 (1984); 1992 Horizontal Merger Guidelines, 4 Trade Reg. Rep. ¶ 13,104 at (continued...)

hospital (or hospitals) in the network have less than 30% of the service capacity in the market.⁶ Indeed, vigorous price competition is likely to intensify and thrive whenever three or more integrated networks are able to compete in a market for the business of employers and health plans.

In order to encourage the development of procompetitive networks, whether fully integrated or partially integrated, exclusive or non-exclusive, the AHA recommends that the creation or formation of such a network not be subject to challenge if either of the following conditions is met: 1) with respect to any service that is required by another network to offer a competing product, the network's service capacity is not greater than 30% of the total service capacity in the market;⁷ or 2) two other viable networks are operating, or can operate, within the market.

⁵(...continued)

20,570-71 (hereinafter "Merger Guidelines"). In contrast, monopoly power has been characterized as something more than market power. Eastman Kodak Co. v. Image Technical Servs., Inc., 112 S. Ct. 2072, 2090 (1992). Typically, market share is used as a surrogate for market power and monopoly power. Id. at 2081, 2090.

⁶ The Department itself has indicated its approval of many similar arrangements. See Remarks of James Rill, Assistant Attorney General, before the National Health Lawyers Association on February 15, 1991 (hereinafter "Rill Remarks"); Letter to George Miron from Anne Bingaman, Assistant Attorney General, dated December 8, 1993; See also FTC Statement at 48991. Although, these statements do not involve exclusive arrangements, courts have indicated that in health care markets, even exclusive arrangements involving not more than 30% are unlikely to create competitive concerns. Jefferson Parish, 466 U.S. at 26; See U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 596 (1st Cir. 1993); See also U.S. Anchor Mfg. v. Rule Industries, Inc., 7 F.3d 986 (11th Cir. 1993) (a firm with less than 50% of the relevant market cannot have a dangerous probability of achieving monopoly in that market).

⁷ Ordinarily, there is sufficient market data to differentiate hospitals by percentage of capacity available. However, the same type of data is not typically available with respect to physicians. Therefore, we anticipate that in most cases the number of network physicians providing a particular service, as a percentage of all physicians providing that service in the market, will be used as a rough surrogate for the physician services capacity of the network for each type of physician service.

Networks Outside the Proposed Safety Zone

Where the formation of networks falls outside of the proposed safety zone, we suggest that rule of reason or merger analysis should be applied. The existence of market power should be the primary focus of any analysis of network formation and operation for networks operating outside the proposed safety zone.⁸ Fully and partially integrated networks without market power are unlikely to harm consumers. Therefore, if an integrated network does not have market power, it should generally be free from antitrust scrutiny.

Our conception of some of the issues involved in analyzing these networks follows. While the same principles would apply to all network formation, the application of the principles may vary depending on whether the network is fully integrated or partially integrated and whether the arrangement is exclusive or non-exclusive.

Partially Integrated Networks

Partially integrated networks involving hospitals that fall outside the proposed safety zone, as a general matter, are appropriately subject to rule of reason analysis. Although the rule of reason analysis described in the sixth Policy Statement is also germane to the analysis of such networks, we have identified at least three issues requiring additional clarification: exclusive arrangements, joint pricing and service specialization.

Exclusive Arrangements

The threshold issue in analyzing the contractual arrangements of partially integrated networks is the "foreclosure" effects of exclusive arrangements.⁹ Agreements that prevent providers from

⁸ An assessment of market power requires an analysis of the relevant market, which is often a difficult task in the context of network development. The initial focus of the restraint is likely to be in the market for some, or all, provider services. However, many restraints created by the development of networks ultimately may affect a health financing market. Courts have been reluctant to find specialized health care financing markets. U.S. Healthcare, 986 F.2d at 598-9. Nevertheless, any analysis of health care financing markets should determine whether particular financing arrangements represent a separate product market. Id.

⁹ U.S. Healthcare, 986 F.2d at 595.

selling their services except through the network (commonly known as "exclusive output contracts") may foreclose health plans not affiliated with the network from purchasing the services of the contracting providers.

If all or most of the physicians or hospitals available to provide primary care services, or one or more critical specialty services -- i.e., obstetrics or cardiology -- are bound by an exclusive arrangement, that arrangement will effectively foreclose competition in the market, although other types of physician or hospital services remain available.¹⁰ In contrast, an exclusive arrangement that only forecloses the supply of medical or hospital services not essential to the operation of a network, or a health plan, would rarely have anticompetitive effects on network services. Therefore, an analysis of the type of services foreclosed is required.

In addition, the duration and termination penalties of the exclusive arrangement may affect its potential foreclosure effects.¹¹ For example, an exclusive contract for only one year that includes a termination at will provision, without a substantial penalty, is not likely to have any anticompetitive effects, even if a significant number of physicians is involved.

Joint Pricing

The pricing policies of partially integrated networks often raise antitrust questions. However, a simple joint offering of price by independent providers involved in a partially integrated network operating outside the proposed safety zone should not involve any exercise of market power so long as the contractual arrangements are non-exclusive and the offer does not involve any tacit or explicit threat of boycott. To the extent a health plan, or other purchaser, or potential purchaser, objects to a joint pricing proposal, the health plan or purchaser has the option of dealing independently with the network's participants.

The potential purchaser would also be free to make a counter offer to the network. Under these circumstances, the network

¹⁰ Of course, efficiencies, which are discussed in more detail below, may be sufficient to justify such arrangements.

¹¹ As noted by the FTC, there are economic reasons that would prevent physicians necessary for competing panels from entering into long-term exclusive arrangements. Zuckerman Letter at 3. However, health plans with market power may be in a position to "force" such physicians into exclusive arrangements.

should be able to negotiate further with the purchaser under pre-set conditions individually established by the network participants. Indeed, the Department has permitted such offerings even in the context of consent decrees with non-integrated networks.¹² Additional guidance in the form of policy statements or guidelines, which are more widely available and carry more force than consent decrees, would be helpful.

Service Specialization

Hospitals forming a partially integrated network may be motivated by a desire to improve the utilization of their respective service capacities in order to achieve better economies of scale. In addition, hospitals may recognize that some members of the network have reached singular levels of excellence in different service areas. To achieve greater economies of scale and take advantage of their strengths in different service areas, the network hospitals may desire to concentrate particular services in individual facilities.

The line dividing "naked" service allocations from cost-saving or quality-enhancing service specializations, as well as the distinction between permissible and impermissible exclusive agreements and joint pricing arrangements, needs to be delineated. The AHA suggests that the example described below can assist the Agencies in articulating the analytical basis for their conclusions.

Hospital A and Hospital B decide to form a hospital/physician network. Hospital A is a traditional community care facility of 150 beds. Hospital B is a 200-bed facility offering primary and secondary level hospital care, with some limited tertiary care services. Unlike Hospital B, Hospital A offers only very limited cardiac care services. The two hospitals are both non-profit, tax exempt, community hospitals with substantial local employer representation on their Boards of Trustees. The only other hospital in the community, Hospital C, is a 300-bed hospital combining some primary and secondary care with a predominantly tertiary care mix.

Hospitals A and B, along with a substantial portion of their medical staffs, form a partially integrated network through non-exclusive contractual arrangements, which include provisions for quality assurance and utilization review. Because the network

¹² See United States v. Massachusetts Allergy Society, Inc., No. 92-10273H (D. Mass. 1992) (Consent Decree at 2-3).

arrangements are non-exclusive, both hospitals are able to participate in other networks, if such networks are formed.

The network hospitals together represent 55% of the staffed beds in the community and approximately 60% of the licensed physicians. The market is dominated by three large employers, which together comprise 50% of the private health insurance market. Medicare and Medicaid are responsible for approximately 40% of hospital revenues, but 50% of hospital costs. Most of the residents of the community are not willing to seek primary or secondary hospital care from hospitals located in other communities, although some residents are willing to obtain tertiary care elsewhere.

The hospitals agree that they can more effectively service network consumers if all cardiac care cases coming in under network contracts are referred to Hospital B, while all routine OB/GYN will be referred to Hospital A. The hospitals expect that ultimately their network business will comprise up to 65%-70% of their total business and that the volume of non-network business will not be sufficient to support a cost efficient OB/GYN unit at Hospital B or the provision of cardiac care services by Hospital A. The hospitals therefore agree to refer both network and non-network OB/GYN cases to Hospital A, and refer both network and non-network cardiac care cases to Hospital B.

In connection with the network's formation, the two hospitals agree to market jointly a managed care product to the three large employers, as well as to other employers, and all insurance company purchasers. The network wishes to make joint offers regarding both hospital and physician prices on a discounted fee-for-service basis. One of the three large employers has already asked the network whether it would be willing to provide services on the basis of a fee schedule developed by consultants hired by the employer, and the network participants (both hospitals and physicians) have agreed to the schedule. The network wishes to offer the same schedule to all the other employers and insurers doing business in the community.

In addition to the discounted fee-for-service product, the network also wishes to offer a risk-based capitated product. The hospitals agree that they are free to participate in other, non-network capitated arrangements.

- Are the Agencies likely to challenge the formation of the network, or the ancillary agreements relating to the referral of OB/GYN and cardiac care services?

- Would the Agencies object to the discounted fee-for-service joint offering to the employer that requested it? To other employers and insurers? If not, would it matter that the two hospitals and the physicians also have authorized the network to accept counter offers from other employers so long as those counter offers were not more than 10% below the fee schedule initially offered by the network?
- Would the Agencies be likely to object to the offering of the capitated product under these circumstances? Would the Agencies be likely to object to the offering of the capitated product if it were offered on an exclusive basis, with the hospitals agreeing that they would not offer any capitated product except through the network? If the Agencies would object to an exclusivity provision, what difference would it make if the capitated product would not be available but for the provision? To what extent would the term of the exclusive agreement or the restrictiveness of any termination provisions be considered by the Agencies?

Fully Integrated Networks

With respect to fully integrated networks operating outside the proposed safety zone, it is usually appropriate to apply merger analysis. Because hospital markets typically are highly concentrated, a mechanistic application of merger analysis can lead to the incorrect conclusion that the Agencies are likely to challenge hospital participation in such networks. For that reason, the Department and the FTC have acknowledged that the "Agencies often have concluded that an investigated hospital merger will not result in a substantial lessening of competition in situations where market concentration might otherwise raise an inference of anticompetitive effects."¹³

The operation of hospital markets typically differs significantly from the operation of more traditional markets. Hospital markets are characterized by product differentiation and/or substantial overcapacity. In fact, some hospital markets would be natural monopolies once excess capacity is eliminated from the market. Moreover, there are often major purchasers that are able to counteract the bargaining power of the hospitals, even after a merger or acquisition. The Agencies have indicated that at least

¹³ Policy Statement No. 1.

some of these factors could be considered.¹⁴ What is needed, however, is a more complete articulation, in the context of network formation and operation, of the ways in which various factors can counteract the inference of anticompetitive effects created by market concentration. The AHA recommends that the Agencies use the following example to explain how they analyze these factors.

The only two hospitals in a community, both private, non-profit, charitable institutions, form a fully integrated network. One hospital is affiliated with a religious group, and the other is not. The hospitals both provide primary and secondary care, but little tertiary care. Residents of the community are generally unwilling to obtain primary and secondary hospital care in other communities, which are no closer than a 45 minute drive, but are willing to obtain tertiary care elsewhere. The religious hospital has 150 licensed beds and the non-religious hospital has 130 licensed beds. However, the level of staffed beds is low. Specifically, the religious hospital only staffs 110 of its beds, while the non-religious hospital only staffs 90 of its beds.

Two employers comprise 60% of the privately insured population of the community. Medicare and Medicaid represent more than 50% of inpatient hospital revenues. During the past one and one-half years, the average daily census for both hospitals has been between 40 and 50 patients, and consultants hired independently by each hospital have come to the same conclusion: within 5 years the community will only be able to support one hospital, notwithstanding the fact that both hospitals are currently making money. As a favored option, both sets of consultants have independently recommended that the hospitals consider consolidation, as part of a network which would include a new multi-specialty group practice sponsored jointly by the hospitals. The consultants estimate that participation in a new, fully integrated network would reduce the cost of hospital services 10-15%.

The hospitals' participation in the fully integrated network is estimated to provide only one third of the revenue necessary to sustain the consolidated hospital and, as a consequence, it will presumably continue to offer hospital services to other networks, and to patients unaffiliated with any network. The new multi-specialty group would be available on a preferential basis to patients of the integrated network. Nevertheless, there are enough other doctors in the community to support the development of two additional networks, one built around an existing multi-

¹⁴ See Policy Statement No. 1.

specialty group, and the other an open panel network built around other private practicing physicians currently available in the community.

- Would the Agencies be likely to challenge the creation and/or operation of such a fully integrated network? Would the price of hospital services offered to all the networks be relevant to the Agencies' analysis?

Exclusions From Networks Operating Outside the Proposed Safety Zone

An area of concern to both fully and partially integrated networks operating outside the proposed safety zone is the exclusion of providers. Providers excluded from networks often bring claims for violations of Section 1 of the Sherman Act, asserting that the network is engaging in an illegal boycott.¹⁵ These claims have generally been unsuccessful because the plaintiff has been unable to establish either the existence of market or monopoly power, or anticompetitive effects.¹⁶

A portion of the nation's population live in sparsely populated regions, and it will not be possible to establish competing networks in all geographic areas.¹⁷ Where networks possess natural monopoly power in either physician or hospital markets, or both, the antitrust laws prohibit networks with such power, or a dangerous probability of attaining such power, from engaging in

¹⁵ Capital Imaging Assocs. P.C. v. Mohawk Valley Medical Assoc., Inc., 996 F.2d 537 (2nd Cir.), cert. denied, 114 S. Ct. 388 (1993).

¹⁶ Id.; Hassan v. Independent Practice Assocs., 698 F. Supp. 679 (E.D. Mich. 1988); Williamson v. Sacred Heart Hospital, No. 89-30084-RV (N.D. Fla. May 28, 1993) (appeal filed); but see, Hahn v. Oregon Physicians' Serv., 868 F.2d 1022 (9th Cir. 1988), cert. denied, 493 U.S. 846 (1989).

¹⁷ One widely accepted study has concluded that approximately 30% of this country's population live in areas that would not support more than one full service provider network. Kronick, R. Goodman, D. and Wennburg, J., "The Market Place Health Care Reform: The Demographic Limitations of Managed Competition," 328 New England Journal of Medicine, 148 (January 14, 1993).

exclusionary or predatory conduct.¹⁸ When a network with natural monopoly power excludes providers from the network, the conduct may be characterized as predatory or exclusionary.¹⁹

Nevertheless, the Agencies have recognized procompetitive justifications and market efficiencies associated with the formation of provider networks.²⁰ Therefore, the mere fact that conduct may exclude competitors of the physicians or hospitals involved in the network should not be determinative. "Liability turns, then, on whether valid business reasons can explain [the defendant's] actions."²¹ The Agencies can play a useful role in emphasizing the appropriate analytical considerations that come into play with respect to exclusions from networks.

Tying Contracts Involving Networks Operating Outside the Proposed Safety Zone

A final area of concern to both partially and fully integrated networks operating outside the proposed safety zone is the joint marketing of different services, which may be analyzed as tying contracts under certain circumstances. Technically, tying contracts are governed by per se analysis rather than the rule of reason. Nevertheless, market power remains an essential element in determining liability.²² Therefore, an agreement between providers of medical services in different relevant product markets to sell their services jointly on an exclusive basis may constitute a tying contract under Section 1 of the Sherman Act if the providers have market power in one or more of the markets. For example, if a hospital with market power in the hospital services market jointly markets its services exclusively with certain physicians on a fee-for-service basis, the conduct is

¹⁸ Trans Sport, Inc. v. Starter Sportswear, Inc., 964 F.2d 186, 189 (2nd Cir. 1992); see also Spectrum Sports Inc. v. McQuillan, 113 S.Ct. 884, 890, 1993; Kodak, 112 S.Ct. at 2090-91.

¹⁹ Alternatively, the conduct could be classified as a boycott, but the analysis would be the same.

²⁰ Policy Statement No. 6.

²¹ Kodak, 112 S.Ct. at 2091 (citing Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585, 605); United States v. Aluminum Co. of Am., 148 F.2d 416, 432 (2nd Cir. 1945).

²² Jefferson Parish, 466 U.S. at 19-22.

likely to be analyzed as a tying contract.²³ In contrast, risk-based products involving both hospital and physician services often must be sold jointly, if at all. If a network offers a single capitation for its package of physician and hospital services on an exclusive basis, the offering should be characterized as a single product. Again, the Agencies could provide useful clarification on this point.

2) Joint Ventures Involving Services or Existing Equipment

The AHA is also seeking additional Agency guidance regarding certain joint ventures. Although the second Policy Statement addresses joint ventures involving new high technology or expensive equipment, it fails to address the joint venturing of existing equipment or new or existing services. The extension of this Policy Statement to such joint ventures would assist hospitals and other providers in their efforts to reduce costs and increase efficiency.

Antitrust Basis for Expansion of Policy Statement.

At its core the second Policy Statement is consistent with traditional antitrust analysis of joint ventures in other industries as well as with other guidelines of the Department and policy speeches of both agencies -- none of which is limited to new equipment ventures. In essence, the Policy Statement addresses the two broad categories of joint ventures that the Supreme Court has recognized as procompetitive: 1) the joint venture that is necessary to make the product or service available at all,²⁴ which appears to be the basis for the antitrust safety zone; and 2) the joint venture that results in productive efficiencies by producing more output per unit of input.²⁵

²³ Jefferson Parish, Id. at 19, 21-22; Collins v. Associated Pathologists, Ltd., 844 F.2d 473, 477 (7th Cir. 1988), cert. denied, 488 U.S. 852 (1988).

²⁴ Cf. Broadcast Music, Inc. v. Columbia Broadcasting, Inc., 441 U.S. 1, 23-24 (1979).

²⁵ Cf. Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co., 472 U.S. 284 (1985). Cognizable efficiencies include economies of scale, better integration of production facilities and similar efficiencies relating to specific operations of the merging firms. Merger Guidelines § 4.

Significantly, the underlying legal basis of both the safety zone and the rule of reason analysis is not limited to only equipment ventures but is equally applicable to products and services²⁶ and to existing ventures of both. As one FTC official recently noted:

Joint ventures normally are created to generate efficiencies, so that an existing product or service can be offered at less cost or that a new product or service can be offered at all.²⁷

Applicability to Service Joint Ventures.

The underlying rationale for the second Policy Statement should make it applicable to proposed joint ventures offering services. The existing Policy Statement could be interpreted to provide that clinical services which a hospital cannot profitably offer on its own may be jointly offered; however, in order to avoid confusion, it would be helpful to expand the Policy Statement expressly to include shared services.

The expanded safety zone should treat shared service joint ventures in the same manner it treats joint ventures involving equipment. Therefore, to qualify for an antitrust safety zone, the shared services joint venture may include only the minimum number of hospitals whose participation is necessary to support

²⁶ There is no anticompetitive effect when the "joint venture participants do not compete in the joint venture market and are not likely to begin doing so in the near future independently of the joint venture." Department of Justice, Antitrust Enforcement Guidelines for International Operations, § 3.42, 4 Trade Reg. Rep. (CCH) ¶13,109 (1988) (hereinafter "International Guidelines"). Under those circumstances "the joint venture would not eliminate competition, but would increase production capacity in the joint venture market." *Id.* A venture is less restrictive where "independent pricing, output, or marketing discretion [is reserved] to the individual venture members." *Id.* at § 3.42; Case 6.

²⁷ Mark J. Horoschak, Antitrust Perspectives on Joint Venturers Among Health Care Providers, Remarks before the American Bar Association Section of Antitrust Law, 1 (Aug. 11, 1992) (emphasis added) (hereinafter "Horoschak Remarks").

the services;²⁸ if additional hospitals are included in the venture, they must not be able to offer the service profitably on their own or through the formation of a competing joint venture.

For example, where two hospitals establish a joint venture to provide highly sophisticated oncology services where neither individually provided or could have provided such services, the proposed antitrust safety zone should be applicable. The safety zone would also only protect a single service venture supported by all the hospitals in the community if such a venture were necessary to generate sufficient volume to provide the service on a profitable basis. On the other hand, if the market could support more than one supplier of such service on a profitable basis, a rule of reason analysis would be applicable to assess its legality.

This rule of reason analysis also provides an opportunity for the Agencies to offer guidance with respect to the market power of joint ventures. Where the joint venturers elect to operate jointly owned equipment or to sell a shared service, the permissible market share of the venture is likely to be that permitted under the Merger Guidelines, which under the Herfindahl-Hirshman Index is generally 30-35%.²⁹ Where, however, the joint venturers remain competitors in the sale of the jointly owned equipment or shared service, a higher concentration threshold is appropriate.

Applicability to Existing Equipment or Service Joint Ventures.

The second Policy Statement also fails to address the joint venturing of existing equipment or services. While the antitrust analysis is necessarily more complicated under these circumstances, the approval of such joint ventures is not without precedent,³⁰ and the antitrust safety zone and tailored rule of

²⁸ The objective evidence necessary to qualify for this safety zone would include the cost to provide the service on an annual basis, the minimum numbers of procedures that must be provided annually to reach the financial break-even point, the number of procedures likely to occur within the year given the demographics of the area and the expected price per procedure.

²⁹ International Guidelines, § 3.42. See also Rill Remarks (collaborative agreement with less than 31.6% of providers in relevant market not viewed as suspect under HHI).

³⁰ International Guidelines, § 3.42 n. 95.

reason analysis in the Policy Statement offer a means of assessing the anticompetitive effects of joint ventures involving existing equipment or services.

For example, if equipment already purchased by a single hospital is too expensive for the hospital to recover its costs of purchasing, operating and marketing the equipment over its useful life, then the safety zone should allow the hospital to participate in a joint venture with other hospitals that do not own such equipment to the extent necessary to allow all venturers to obtain their costs of purchasing (or using), operating and marketing the equipment over its useful life. Similarly, where a hospital offers a clinical service which, given the cost of offering the service, its patient base is too small to support, then other hospitals which do not offer such service should be allowed to participate in the venture to the extent necessary to provide the requisite patient base to support such service. In both instances the marketplace would dictate the necessity for the consolidation of the existing equipment or services.

Where the other hospitals joining or forming the venture currently own and operate similar equipment, the pooling or replacement of such equipment with jointly owned equipment would be analyzed as a merger outside the proposed safety zone.³¹ Similarly, where the other hospitals currently provide a particular service, the joint provision of such service would have the same competitive effect as a merger and should be analyzed as such.³²

Perhaps the more difficult analysis is where the potential joint venturer could have entered the market independently. Under these circumstances a rule of reason analysis would be

³¹ Horoschak Remarks. However, if the joint venturers each continued to sell products or services in competition with the venture and therefore with each other (such as when two hospitals with separate MRIs, operating at over-capacity, jointly buy and operate a third MRI), or (as in the case of a production joint venture) each separately priced and sold the products of the venture in competition with each other, there would not be the wholesale elimination of competition between the firms, and rule of reason analysis rather than traditional merger analysis should apply.

³² Cf. International Guidelines, § 3.42; Case 7.

applicable.³³ However, even where two hospitals may not be necessary financially to support a venture of existing equipment or service, there would be circumstances under a rule of reason analysis where the venture would be lawful.

The AHA recommends that, in order to explain how joint ventures of services are analyzed under the rule of reason, the Agencies describe how they would analyze the following example.

In a five-hospital market which, based on the demographics in the market, could financially support two inpatient rehabilitation centers, Hospital A, which does not provide this service, wants to venture with Hospital B, which already provides this service but has additional capacity. Another hospital in the market provides inpatient rehabilitation services. A consultant's report indicates that increased patient volume should increase efficiency from both an economic and quality point of view of the rehabilitation services provided. Hospitals A and B intend to develop a single fee for this service.

- Would the Agencies be likely to challenge the venture? Why or why not?
- Would the Agencies' response be different if, prior to the venture, Hospital B was the only hospital in the market providing inpatient rehabilitation services?
- What additional information, if any, would the Agencies need before making a decision?

3) Efficiency Justifications for Mergers and Joint Ventures

Both the Department and the FTC have previously recognized that mergers and joint ventures can be efficiency enhancing. Indeed, in the Merger Guidelines both Agencies recognized that some mergers which might otherwise be challenged may be reasonably necessary to achieve certain net efficiencies. In addition, both Agencies expressed a willingness to consider other efficiencies resulting from reductions in general selling, administrative, and

³³ See, e.g., Berkey Photo, Inc. v. Eastman Kodak Co., 603 F.2d 263 (2nd Cir. 1979) (important consideration is likelihood that one of the venturers would have undertaken similar venture independently).

overhead expenses, although the Agencies indicated that such efficiencies may be difficult to demonstrate.³⁴

In previous business review letters, the Department has stated its intention not to challenge certain joint venture arrangements, such as PPO arrangements, which would achieve efficiencies by expediting negotiations and facilitating the contracting process.³⁵ In other business review letters, the Department has indicated its intention not to challenge PPO arrangements which achieved such efficiencies as centralized billing, claims processing, utilization review for third-parties, joint marketing, and debt collection.³⁶

Although the above statements purport to recognize that certain efficiencies can justify mergers or joint ventures that might otherwise be challenged, health care providers need better to understand how the Agencies balance the achievement of efficiencies against the potential lessening of competition between the parties to a merger or joint venture. The Merger Guidelines seem to contemplate a sliding scale -- requiring greater net efficiencies if the merger has greater potential anticompetitive effects.³⁷ Therefore, if the efficiencies achieved from a joint venture or merger are likely to be substantial and the anticompetitive effects are likely to be

³⁴ Given the significant over-capacity of beds in the hospital industry, primarily due to prior government encouragement of hospital construction under the Hill-Burton Act, mergers of hospitals will have more potential to achieve efficiencies than would be likely in almost any other industry.

³⁵ See Letter to Gregory G. Binford, Esq. from Mark Gidley, Acting Assistant Attorney General, dated January 7, 1993, stating no enforcement intention to challenge Case Western Reserve University School of Medicine and University Hospital Cleveland plan to use a single agent to negotiate contract terms and fees with third-party payors on behalf of 13 separate physician practice groups providing care at University Hospital. The Department viewed these groups as not competing with one another.

³⁶ See Letter to Frank Sanchez from Charles Rule, Acting Assistant Attorney General, dated October 3, 1986, stating no intention to challenge a pharmacy joint venture called Service For You which would negotiate contracts for pharmacy members with third-party payors to provide drugs and services to subscribers of the third-party payors.

³⁷ See Merger Guidelines, § 4.

insignificant, such as a merger or joint venture in a community where other competitors still remain after the merger or joint venture, in contrast to a community where no competitor (or only one) would remain in the relevant market, then the efficiencies should overcome concern over potential anticompetitive effects. It is not clear, however, how the Agencies view these and other factors.

To clarify the Agencies' position on efficiencies, the AHA suggests additional guidance addressing the following questions:

- To what extent does the existence of strong competition remaining in the geographical area influence the Agencies to give more weight to the efficiencies generated by the merger or joint venture?
- If the joint venture will result in cost-savings, will the Agencies view the transaction more favorably if the venture is non-exclusive, rather than exclusive?
- What types of efficiencies (or what amounts saved as a result of the merger or joint venture) would the Agencies find sufficient so as not to challenge a particular merger or joint venture?
- If outside consultants identify the types and amounts of efficiencies at an early stage before the transaction is completed, will the Agencies view the estimate more favorably than if the estimate is made after the agreement is executed?
- If the joint venture will increase the potential for improving the quality of care by the venturers, will this enhancement of quality be an important efficiency in the view of the Agencies?

To address these issues, the Agencies might consider using the following example.

Assume there are five hospitals in a relevant geographic market, and currently three hospitals offer cardiac catheterization services and one of those also offers open-heart surgical services. Hospital A operates its cardiac catheterization services at an annual profit of \$100,000. (Hospital A is also the only facility in the area approved by the State to provide open-heart surgical services.) Hospitals B and C provide only cardiac catheterization services and have reported losses of \$100,000 each for the past three years in providing those services.

Hospitals B and C commission a study by the health consulting subsidiary of a Big Six Accounting Firm, which concludes that if Hospitals B and C were to joint venture their existing cardiac catheterization services, they could save a total of \$250,000 per year through eliminating the duplication of staff and equipment and agreeing that all cardiac catheterization services will be performed at Hospital B. The study also concludes that the hospitals might be able to generate a sufficiently high volume of procedures together so as to satisfy the minimum State standards for establishing an open-heart program. The State, however, would still retain the right to approve such a program, so there is no guarantee that the open-heart application would be granted.

Hospitals B and C believe that by operating their own joint cardiac catheterization program they would then be able to recruit more cardiac surgeons to the community, and ensure that the two hospitals could compete more effectively with Hospital A for managed care contracts requiring provision of cardiac catheterization procedures, and potentially for provision of open-heart services.

- Based on the efficiencies expected to be achieved in the above example, would the Agencies be likely to challenge the joint venture?
- Would the Agencies have any different view if there would be at least two other hospitals offering cardiac catheterization services, rather than only Hospital A, after Hospitals B and C formed the joint venture?
- Would the Agencies view the efficiencies differently if Hospitals B and C were not currently losing money, but instead were merely breaking even on their existing cardiac catheterization services?
- What additional information, if any, would the Agencies need before determining whether the efficiencies generated by the proposed joint venture would exceed any competitive harms caused by the venture?

4) State Action Doctrine

In the last two years, at least 15 states have enacted special laws to facilitate cooperative agreements between hospitals and

other health care providers.³⁸ These enactments -- frequently termed "hospital cooperation acts" -- involve some type of state regulation and approval of arrangements between otherwise competing hospitals or hospitals and other health care providers.³⁹ The statutes almost always contain provisions by which the state's approval of the cooperative arrangement is intended to confer an exemption from the state's antitrust laws and "state action immunity" from liability under federal antitrust laws.

While the Supreme Court has provided reasonably clear guidance on what a state statutory regime must provide in order to satisfy the first of the two state action immunity criteria -- articulating a policy to displace competition with regulation -- and the various state hospital cooperation acts appear to meet these standards,⁴⁰ there has been little guidance concerning the second criterion -- active state supervision of the potentially or actually anticompetitive conduct. The decision in F.T.C. v. Ticor Title Ins. Co.,⁴¹ which rejected state action immunity for so-called "negative option" rate regulation, has engendered some uncertainty concerning the efficacy of the various state hospital cooperation acts in affording state action immunity on state-approved arrangements. As the former Director of the FTC's Bureau of Competition observed:

Whether the [hospital cooperation acts] will indeed confer any federal immunity after the Ticor decision is open to question. Ticor emphasizes the importance of limiting "state action" immunity for private actions to cases where the state effectively oversees what is being done in its name. It remains to be seen how closely states will scrutinize private decisions

³⁸ See, e.g., Maine Hospital Cooperation Act (22-A M.R.S.A. §1881 et. seq.); Colorado Hospital Efficiency and Co-operation Act (Colo. Rev. Stat. 24-32-2701 et seq.).

³⁹ See, e.g., Maine Hospital Cooperation Act (22-A M.R.S.A. §1881 et. seq.); North Carolina (NC Stat. § 131E-192.1); Washington (R.C.W. § 15.21.020).

⁴⁰ See, e.g., Maine Hospital Cooperation Act (22-A M.R.S.A. §1881 et. seq.); North Carolina (NC Stat. § 131E-192.1).

⁴¹ 112 S.Ct. 2169, 119 L.Ed.2d 410 (1992).

approved under the statutes and regulate their implementation.⁴²

More recently, in a staff letter to North Dakota's Assistant Attorney General, the FTC's Office of Consumer and Competition Advocacy questioned whether two bills then pending before the North Dakota legislature would require sufficient state supervision to confer state action immunity for state-approved agreements between health care providers:

Both of these bills would require that applications for certificates be reviewed and specifically approved before the certificates would be issued, but neither calls for subsequent scrutiny of the parties' actual operation, except by providing generally for the possibility of reexamination and revocation. More particularized scrutiny of actual conduct under these agreements may not only be desirable to ensure that they continue to serve their intended purposes, but might also be necessary to accomplish the apparent goal of conferring antitrust immunity.⁴³

This uncertainty should be resolved. As one commentator aptly put it:

It would be a terrible result if providers rely upon [these] statutes in entering into cooperative

⁴² "The Role of Antitrust in Improving And Reforming the Health Care System," Remarks of Kevin J. Arquit, Director, Bureau of Competition, Federal Trade Commission, before the ABA Section of Antitrust Law and Health Law Forum, New Orleans, Louisiana, October 15, 1992, pp. 2-3. Private commentators have made similar observations. See H. Feller, "The Impact of Ticor on State Legislation Authorizing Provider Collaboration," Antitrust Health Care Chronicle, Vol. 7, No. 2 (1993) (suggesting that state hospital cooperation acts cannot assure state action immunity for state approved collaborative arrangements unless there is mandatory annual review and re-approval of the arrangement); K. Grady, "The Role of Antitrust in a Reformed Health Care System," Antitrust, Vol. 8, No. 1 (Fall 1993), p. 4. ("Initially, there may be antitrust litigation over whether activities consistent with state statutes qualify for state action immunity.")

⁴³ Letter, Michael O. Wise, Acting Director, Office of Consumer and Competition Advocacy, Federal Trade Commission, to The Honorable David W. Huey, Assistant Attorney General, State of North Dakota, March 8, 1993, p.13 (hereinafter "Wise Letter").

agreements, and then later learn that their activities are not immune from the federal antitrust laws because the state agencies have not sufficiently monitored or supervised the approved cooperative arrangements.⁴⁴

The Clinton Administration has likewise recognized the need for certainty in this area, indicating in its September 7, 1993 summary of the Health Security Act that "the Department of Justice and the Federal Trade Commission [should] publish guidelines that apply the 'state action doctrine' where a state seeks to grant antitrust immunity to hospitals and other institutional health providers."⁴⁵

Consistent with these pronouncements, and the demonstrated willingness of the Department and the FTC to set forth their views to state officials on the antitrust consequences of state legislative and regulatory initiatives in the health care sector,⁴⁶ the AHA respectfully suggests that the Agencies clarify their approach to the "active supervision" requirement of the state action immunity doctrine in the context of state hospital cooperative acts. We believe that the example described on Pages 7-8 of this letter can also serve as a useful example upon which the agencies can frame a clear explanation of their position regarding "active supervision." In addition:

Assume that because they recognize that their arrangement might be viewed as anticompetitive, the two hospitals forming the network described above apply for a certificate of public advantage from a state health agency under the state's hospital cooperation act. The act expressly authorizes the state agency to review and approve cooperative agreements between hospitals if it determines that the benefits from such arrangements outweigh their anticompetitive effects. The agency grants the certificate after concluding that the network will likely provide a favorable balance of benefits to its citizens. In its written decision, the agency concludes that the market for the network services will consist mainly of large "power" buyers, that the hospitals

⁴⁴ See H. Feller, n. 42, supra.

⁴⁵ Summary, "American Health Security Act of 1993," September 7, 1993, p. 170, reprinted in BNA Health Care Policy Report, Special Supplement, September 13, 1993.

⁴⁶ See Letter, Anne. K. Bingaman, Assistant Attorney General, Antitrust Division, Department of Justice, to the Honorable Cynthia M. Maleski, Insurance Commissioner, Commonwealth of Pennsylvania, September 7, 1993; Wise Letter, n. 43, supra.

are not likely to charge a supra-competitive price because of the employer representatives on their Boards, and that patients and payors are likely to benefit from the unit cost reductions associated with allocation of services and improvements in quality attributable to a higher frequency of cardiac care procedures at Hospital B.

The certificate contains a provision requiring the hospitals to file biannually a report with the agency detailing their network activities, including any change in their charges from preceding years and the reasons therefore. State law grants to the agency the authority to seek a court-ordered revocation of the certificate upon a showing that, as a result of changed conditions, the benefits from the arrangement no longer outweigh its anticompetitive effects.

In this situation, where there is state review and approval of the network upon its formation, combined with the requirement of biannual reporting to the state and the state agency's power to seek a revocation of the certificate, is any additional state supervision of the activities of the hospitals necessary to secure "state action" immunity for formation and operation of the network?

If this is not sufficient, which (if any) of the following would be necessary or sufficient to satisfy the active state supervision requirement, and with what frequency?

- The state agency affirmatively re-approving the arrangement? If so, how frequently?
- The state agency approving the hospitals' charges, or approving the hospitals' budgets, or establishing revenue limits for the hospitals?

If the state supervises the activities of the hospitals in the network through revenue, charge or budget controls, is it also necessary for state action immunity that the state review and approve the non-price terms of the contract between the hospitals and payors?

- For example, if a payor requests that the hospital network provide nurse midwife services, but the hospitals decline to do so, must the state affirmatively approve the hospitals' decision not to offer such services?

Conclusion

The AHA appreciates your personal commitment to reducing the uncertainty that health care providers currently face when engaging in joint activities. In this letter we have addressed a number of areas where this uncertainty is most troublesome to providers. Although these issues are complex, their resolution is crucial to encouraging and promoting the reform of our health care delivery and financing systems.

Because the health care field is changing rapidly in anticipation of legislative health care reform, additional guidance is needed as quickly as possible. Joint guidance from the Department and FTC would be particularly welcome, and I therefore urge you to share this letter with the FTC.

I will contact you shortly to discuss how the AHA can best assist you in the development of additional guidance. In the meantime, if you have any questions, please do not hesitate to contact me at (312) 280-6121 or Tracey Fletcher of my staff at (312) 280-6674.

Sincerely,

Fredric J. Entin
Senior Vice President
and General Counsel

WRITTEN TESTIMONY
OF THE
AMERICAN NURSES ASSOCIATION

TO THE
ECONOMIC AND COMMERCIAL LAW SUBCOMMITTEE
COMMITTEE ON THE JUDICIARY
UNITED STATES HOUSE OF REPRESENTATIVES
CONCERNING PROPOSED EXEMPTIONS TO ANTITRUST LAW
FOR THE HEALTH CARE INDUSTRY

JUNE 24, 1994

Introduction

The American Nurses Association (ANA) appreciates the opportunity to provide testimony to the Economic and Commercial Law Subcommittee of the Committee on the Judiciary regarding exemptions to antitrust law which have been proposed for the health care industry. ANA strongly opposes any proposals to create new exemptions or otherwise weaken existing antitrust laws as they apply to health care markets. We believe that such proposals would have the effect of immunizing and encouraging anticompetitive behavior within the health care industry and would operate to the detriment of health care consumers.

The American Nurses Association (ANA) is the only full-service professional organization representing the nation's 2.2 million registered nurses, including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists, through its 53 state and territorial nurses associations.

ANA has been a strong and enthusiastic supporter of health care reform. We believe that, to be successful, health care reform efforts must provide for universal coverage and access to health care services, and must contain rising health care costs, but not at the expense of health care services. ANA supports a reformed health care system that ensures that the health care consumer gets the best health care at affordable prices. We believe that such efforts should include providing health care consumers with a

choice of provider types. Nurses, including advanced practice registered nurses such as nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists, must be fully utilized under a reformed health care system in order to provide full access to high-quality, cost-efficient services. Currently, many barriers stand in the way of nurses practicing to the full extent of their abilities and providing consumers with access to their services. These barriers include: restrictive State scope of practice acts; scope of practice which is limited to geographic or institutional locations; and limited access to professional liability insurance and institutional privileges. Many of these barriers are contained in restrictive state practice acts and in restrictive reimbursement policies by Medicare, Medicaid and private insurers. Some health care reform proposals pending before Congress, including the "Health Security Act" and the "American Health Security Act," would begin to address some of these restrictions and if implemented to the fullest interpretation of the legislation afford consumers the opportunity to choose nurses to provide health care services. It is important that any health care reform proposal address these restrictions if full and fair competition among health care providers is to exist.

Other barriers to competition among providers exist in the behavior of some actors in the health care market that operate to limit consumer choice. Many physicians, for instance, have acted to limit competition from non-physician provider groups--whether these be advanced practice registered nurses, psychologists, podiatrists, chiropractors or other providers. Some have acted to freeze their competitors out of

markets, to deny them hospital admitting privileges, to prevent them from participating on managed care provider panels. Testimony provided to the Committee from our colleagues of the American Association of Nurse Anesthetists and the American College of Nurse Midwives includes several specific examples of these anticompetitive practices and some of the ways in which the antitrust laws have been utilized to fight them. Some of these anticompetitive activities may constitute violations of the antitrust laws and some do not. ANA is convinced that consumers would suffer if anticompetitive activities that are currently prohibited were to be placed outside of the reach of the antitrust laws.

ANA also believes that consumers benefit from continued scrutiny by the Federal Trade Commission and the Department of Justice of planned mergers, acquisitions and other combinations within the health care industry. At a time of immense vertical and horizontal consolidation within the industry, consumers require continued federal vigilance over anticompetitive practices. The authority of the federal government to intervene on behalf of the consumer must be maintained. The ability of individuals to bring private causes of action to halt anticompetitive activities must also be protected.

The health care industry is going through a period of great change. The year 1991 ranked as the third most active year for hospital mergers, consolidation, and acquisitions in a decade.¹ Although merger activity declined in 1992, it is expected that

1

Burda, D. (1993, December 20). Cutting down. *Modern Healthcare*, pp. 49-50, 54, 56, 58.

their incidence will increase again in 1993. A survey reported by Hospitals magazine revealed that more than two-thirds of hospitals had already entered into some sort of collaborative arrangement with another health care provider. By far, the most common partner was another local hospital²

The pace of change in the industry is likely to continue and even accelerate during the implementation of health care reform. At this time of immense change and uncertainty in the market, relaxing the antitrust laws could lead to wide-ranging, unpredictable and harmful results.

Registered nurses oppose any weakening of the antitrust laws because, as advocates for health care consumers, we oppose any measures that could weaken competition, lead to increased prices and lower quality. In addition, we believe that the antitrust laws provide an important weapon to allow nurses to practice their profession and to provide the consumer with access to high-quality, cost-efficient health care. Nurses oppose any efforts to exclude them from markets or otherwise to limit their ability to compete with other providers. Nurses oppose moves among providers to combine to dominate markets, thereby eliminating competition, threatening to result in increased prices and lower quality. We note that the recent rash of hospital mergers and acquisitions has, in some instances, led to a decreased level and range of available health

2

"Survey outlines hospital collaboration efforts" (1993, February 20). Hospitals, p. 56.

care services, decreased utilization of professional nurses.

One antitrust reform proposal which ANA does support and is included in several of the health care reform proposals currently moving through Congress is the proposal to remove the current exemption for the "business of insurance" provided by the McCarran-Ferguson Act as it applies to health insurance. ANA believes that this current exemption has acted to the detriment of consumers by permitting anticompetitive activities by insurance companies, including those in which physicians wield influence. ANA believes that the proposed repeal of this exemption should be broadened to eliminate the exemption as it applies to professional liability insurers as well. This exemption has been used to shield practices that restrict the practice of nurses, including advanced practice registered nurses, by making coverage unavailable or by tying nurses' practices to those of physicians by requiring physician supervision even where this is not a requirement of the relevant state practice acts. In some instances, malpractice insurers (which are often owned by physician groups) have attempted to discourage the practice of advanced practice registered nurses by adding a surcharge to the premiums paid by physicians with whom those nurses collaborate.

Immunity for Activities in Connection with Fee Negotiations

The "Health Security Act" originally designated H.R. 3600 and S. 1757 would create an exemption from antitrust laws for activities conducted in connection with the collective negotiation of provider fees. Such activities would be removed from the reach

of these laws either under the "state action" doctrine or the Noerr-Pennington doctrine.

ANA opposes this broad exemption. The provision for fee negotiations is not spelled out in any detail; it is notable for both its breadth and its vagueness. Many issues of vital concern are left unanswered. It is not clear who would negotiate on behalf of providers, how provider representatives would be determined, or what areas would be within the scope of these negotiations. As devoid of detail as this proposal is, one could envision circumstances wherein, for instance, fee negotiations would include limiting the fees paid to nonphysician practitioners to a percentage of those paid to physicians and/or could sharply limit the circumstances under which consumers could access the services of nonphysicians.

Some have questioned why nurses would oppose this proposed exemption, since it would presumably allow nurses, like physicians, to combine for the purposes of fee negotiations. In the current health care environment, physicians continue to hold more market power as providers than do nurses and, under the proposed exemption, are likely to wield more negotiating power. This, added to the continued presence of other barriers such as restrictive state practice acts, means that the ability of nurses to compete with physicians could be stifled or even eliminated as a result of the proposed exemption. We believe that this is detrimental not only to nurses, but most importantly to consumers, who will be denied the ability to choose the high-quality, cost-efficient health care services which nurses provide.

As much as the proposal for fee negotiations itself presents cause for concern, the proposed antitrust exemption for activities conducted in connection with those negotiations is even more troubling. What kinds of activities would be immunized by this proposal? Would physician groups be able to caucus beforehand and vote as a bloc in fee negotiations? Would they thus be able to exclude nonphysician practitioners from the process, or force through proposals to limit the circumstances under which these practitioners could be utilized or reimbursed, or to limit the amount of their reimbursement? Could they use their joint negotiating power to drive nonphysicians from the market altogether? Clearly, these are results to be avoided, yet there is no indication that they could be prevented under this proposed exemption.

We presume that provider groups would be entitled to vote to set fees and fix prices, since this is evidently the point of the negotiations themselves. We fail to see the need to allow providers to conspire to fix prices. We believe that such activity runs directly counter to the goals of containing health care costs and allowing consumers a choice of services. If the antitrust laws are to continue to apply to the health care industry at all--as, we would submit, is required in order to permit competition and to protect consumers--we see no value in permitting and encouraging price-fixing within that industry.

We also note that the proposed antitrust exemptions in "The Health Security Act" were drafted in the context of a bill that required mandatory health alliances. If these

mandatory alliances are not to be a feature of a reformed health care system, the stated need for such an exemption (to "level the playing field" between providers and insurers) will no longer exist.

H.R. 3486, S. 1658 and S. 1770

Rep. Bill Archer's (R-TX) H.R. 3486, "Health Care Antitrust Improvements Act of 1993", Sen. Orrin Hatch's (R-UT) S. 1658 "Health Care Antitrust Improvements Act of 1993" and Sen. John Chafee's (R-RI) S. 1770 "Health Equity and Access Reform Today Act of 1993" would create a series of new antitrust exemptions. They would expand in many ways upon the joint Policy Statement issued by the Federal Trade Commission (FTC) and the Department of Justice (DOJ) in 1993. Whereas the FTC-DOJ Policy Statement creates various defined "safety zones" to guide providers, these proposals would create immutable statutory exemptions. These exemptions generally involve lower thresholds than the FTC-DOJ safety zones. The bills would also exempt "good faith negotiations" to initiate or engage in activities defined as safe harbors or future safe harbors to be established by the Attorney General. Additionally, the bills detail a mechanism for soliciting proposals for new safe harbors, for review, acceptance and promulgation of rules defining such new safe harbors. The bills also spell out a mechanism for obtaining certificates of review for "collaborative ventures."

In addition, these bills would expand greatly upon the FTC-DOJ Policy Statement's current guidelines for hospital mergers. Intended to permit mergers among

small, rural hospitals where efficiencies can be achieved which would not be otherwise possible, the Policy Statement includes guidelines which apply under carefully limited circumstances under which such mergers could take place. The bills would lower these thresholds and would no longer limit them to small, rural hospitals. ANA believes that it is vital that the enforcement agencies continue their power to scrutinize planned hospital and health care mergers and acquisitions. In too many instances, nursing has seen such mergers result in a lower level and range of health care services. Such mergers have threatened to exacerbate the shortage of services in some communities and to lead to an elimination of some specialized services in some areas. Many mergers have resulted in a reduced utilization of professional staff as hospitals are "streamlined" and "restructured." Ironically, some of these mergers, carried out in the name of "efficiency" and cost-savings, have been so heavily leveraged that they have exacerbated rather than resolved the budget crises of the merged institutions. For instance, California Pacific Medical Center in San Francisco, formed by the merger of Children's Hospital of San Francisco and Pacific Presbyterian Medical Center in 1991, have faced repeated services and staff cutbacks and layoffs since the time of the merger. That merger also led to continuing labor problems at the merged institution, resulting from its decision to terminate recognition of the California Nurses Association, which had represented Children's Hospital nurses for fifty years, as the collective bargaining agent for those nurses.

ANA does not believe by any means that all health care mergers have an adverse impact on competition, health care services and/or the health care workforce. We do

believe that proposed mergers require careful scrutiny by federal enforcement agencies. As noted above, the current FTC-DOJ guidelines have provided the flexibility for many of our nation's small and rural hospitals to merge. In some instances, this has meant the difference between watching a small, community-based health care institution falter and close or allowing it to stay open and continue to serve an underserved rural population. This result has been reached by the enforcement agencies' own willingness to be responsive to current needs for flexibility in antitrust enforcement. It by no means follows that this flexible approach should give way to a rigid exemption that would remove the agencies' power to oversee merger activity by larger, non-rural institutions.

Despite the fact that H.R. 3486, S. 1658 and S. 1770 include some provisions that nurses might otherwise conceivably support (for instance, they broaden those provisions of the FTC-DOJ Policy Statement which currently apply to "physicians" to apply to all "providers"), ANA strongly opposes these bills. While they purport to expand on the current FTC-DOJ Policy Statement, their approach stands in stark contrast to those guidelines. The FTC-DOJ Policy Statement is a statement of enforcement policy that seeks to provide guidance as to certain activities which those agencies will not consider violations of antitrust law. These guidelines can be broadened, narrowed or otherwise adjusted as circumstances and experience dictate. The bills, on the other hand, are not only broader in scope; they would create inflexible statutory exemptions.

This would create an untenable and dangerous situation for our nation's health

care consumers. On the one hand, broad new exemptions to the antitrust laws would be created at a time of great change and uncertainty in the health care industry. At the same time, consumers and providers would have to put up with any untoward effects until such time as the statutes could be further amended; the enforcement agencies would be unable to intervene to halt any harmful antitrust activities undertaken to take advantage of these broad new exemptions.

Continued Role of the Enforcement Agencies

Both the Federal Trade Commission and the Department of Justice have shown a keen interest in and understanding of the health care market. They have displayed a willingness to undertake vigorous enforcement of antitrust laws to promote fair competition within the health care industry and, at the same time, have moved to examine areas where some flexibility and guidance is needed and to formulate changes in their enforcement policies. While we may not be fully comfortable with all of the current enforcement guidelines contained in the FTC-DOJ Policy Statement, we do believe that they represent a much more useful, effective and judicious approach to making changes in antitrust enforcement than do the sweeping and inflexible statutory exemptions that have been proposed in some of the health care reform bills. These proposals would sharply limit the enforcement of antitrust laws and tie the hands of the federal agencies. The American public needs to be assured that these agencies will be able to act on their behalf as needed.

We also note that enacting broad statutory antitrust exemptions would apply not only enforcement activities by the FTC and the DOJ; they would, of course, also prevent private causes of action against anticompetitive activities in the health care industry. Such legal action has been an important area through which individuals and groups, including many nonphysician practitioners, have sought to end anticompetitive and discriminatory activities that violate the antitrust laws. These, too, have served as an important enforcement mechanism to ensure continued competition within the health care industry.

Conclusion

ANA opposes any efforts to weaken antitrust protection at this time. Enactment of broad new antitrust exemptions at a time of tremendous changes in the health care industry would pose a significant risk to health care consumers. We believe that more balanced and judicious approaches are needed at this time. We urge the committee to maintain the ability of current laws to maintain competition and benefit health care consumers.

**STATEMENT OF ANNE K. BINGAMAN
ASSISTANT ATTORNEY GENERAL
ANTITRUST DIVISION
UNITED STATES DEPARTMENT OF JUSTICE**

Submitted to the Subcommittee on Economic and Commercial Law
United States House of Representatives
On Competition and Antitrust Issues in Health Care Reform
June 15, 1994

I am delighted to have the opportunity to submit to the Subcommittee the views of the Department of Justice on the role of competition and the antitrust laws as significant reform of our health system is underway. This Subcommittee knows the vital role that competition plays in the American economy, and the importance of the antitrust laws in preserving that competition. Increasing competition in the health care system will help lead to lower prices, more innovation and increased quality. This will benefit all Americans and is an important goal of any health care reform.

The Vital Importance of Competition and the Antitrust Laws

The antitrust laws have existed for over a century as the principal guarantor of effective competition in free marketplaces. They have proved, time and again, far superior to pervasive government review, regulation, and

oversight of individual or collective activities that may have competitive consequences. Indeed, they have been termed the "Magna Carta" of our fundamental national economic system.

In health care markets, as in other markets, the antitrust laws have played an integral role in protecting consumers from higher prices resulting from efforts to reduce or eliminate price competition and to thwart cost containment. The antitrust laws have enabled innovative health care delivery systems to form and compete in the market by preventing providers from boycotting those systems. Indeed, the success of managed care plans today is directly related to the existence and enforcement of the antitrust laws. The antitrust laws have prevented providers from jointly agreeing to increase their fees above competitive levels and pass those unjustified increases to consumers. The antitrust laws have prevented anticompetitive mergers that would result in diminished services, decreased quality and increased prices. While this is unambiguously good, at the same time, the antitrust laws have not prevented efficiency-enhancing joint conduct likely to lead to improved quality, increased services and lower prices.

In the health care area, as is the case generally, the antitrust laws are enforced so as to take into account not only indications of possible competitive harm, but also the potential for procompetitive increases in efficiency, lowered administrative and other costs, improvements in quality, enhanced innovation, and other factors that are important to the cost-effective delivery of quality health care services. Many joint activities that can lead to lower costs and improved quality occur every day in the health care industry without raising any antitrust issues. Many types of procompetitive activity are well recognized as highly unlikely to raise any significant antitrust concern. For example, neither the Department nor the FTC has ever challenged a joint venture among hospitals to purchase, operate and market high-technology or other expensive medical equipment. With hospital mergers numbering in the hundreds and hundreds, the Department and the FTC investigate and challenge only a very small percentage—those transactions which, instead of producing significant efficiencies that will lower prices to consumers, will result in decreased competition and harm consumers by resulting in higher prices. The Department and the FTC's enforcement record makes clear that only those activities that would harm health care markets and consumers by raising prices, decreasing the availability or quality of services, or discouraging innovation face potential antitrust challenge.

As the debate on health care reform moves forward, it is important to realize, remember and preserve the vital role that the antitrust laws have in ensuring that health care markets will continue to function competitively.

Antitrust Guidance to the Health Care Community

Although antitrust principles in the health care area are basically sound, the Department and the FTC have recognized that antitrust uncertainty in the health care community, particularly in these changing times, should be addressed. To that end, we have been working since last summer to provide antitrust guidance to the industry. In September 1993, we issued six Statements of Antitrust Enforcement Policy in the Health Care Area, covering the following areas:

- Hospital mergers
- Hospital equipment joint ventures
- Physicians' provision of information to purchasers
- Hospitals' exchange of price and cost data
- Joint purchasing arrangements among providers, and
- Physician network joint ventures.

These six areas were chosen after discussions with many members of the health care industry. We wanted to focus on those areas of greatest concern to the health care community. We recognized that industry participants could (and did) provide important input to the Department and the FTC on those areas that most concerned the health care community regarding the application of the antitrust laws. We responded to those concerns in these statements. In working on these statements, we paid particular attention to concerns regarding the application of the antitrust laws in rural health care markets.

Our statements contain "safety zones" describing mergers, joint ventures, and other activities that the agencies have concluded are very unlikely to raise competitive concerns. The statements also make clear, however, that conduct that does not fall within the safety zones is not by implication likely to be challenged by the Department or the FTC. Indeed, much conduct not amenable to coverage by a safety zone because of the significance of the particular circumstances will be recognizably and demonstrably procompetitive in those circumstances. The statements set out the analysis the agencies use in evaluating conduct outside the safety zones so that health care providers may

more confidently assess antitrust issues raised by proposed conduct even if the safety zones themselves are not applicable.

Both the safety zones and the agencies' analysis of other conduct are set out in our policy statements in simple, straightforward terms. Our goal is to provide antitrust guidance to health care providers themselves, and not only to the antitrust bar that advises the industry.

While our 1993 policy statements cover a lot of ground and, I believe, have contributed greatly to health care providers' understanding of antitrust issues, I also believe that we can and should do more. When we issued our policy statements last September, we recognized that additional antitrust guidance in the areas they cover as well as in other health care areas may be desirable. We are hard at work on such additional guidance right now, and have pledged to continue this effort. In this regard, I want to express my sincere appreciation for the advice and counsel we have received from representatives of the health care community in our ongoing efforts to develop useful antitrust enforcement policy statements. The legal and practical insights that have been

shared with us by the American Hospital Association, the American Medical Association, and a variety of other interested and knowledgeable parties have been invaluable.

We have also instituted an expedited procedure to supplement the general antitrust guidance set forth in the Statements of Antitrust Enforcement Policy in the Health Care Area with more specific guidance on specific proposed conduct. We have committed to respond to requests for Department business reviews of specific health care activities within 90 or 120 days, depending on the nature of the conduct. The Federal Trade Commission has made the same commitment with respect to its advisory opinion procedure.

The Department has committed substantial resources to the health care business review process and I am proud of the results thus far. We have issued health care business reviews on a number of important topics in the health care industry, including group purchasing by employers of health care benefits (which can hold down health care costs), provider networks (an area of increasing importance to the provider community), and wage and salary surveys (conduct often engaged in by hospitals). We expect to continue promptly to

address these and other topics important to the health care community. Health care providers are taking advantage of these procedures, and we anticipate that they will result in significant further clarification of antitrust rules and guideposts to the advantage of all.

Competition and the Health Security Act

The President's proposed Health Security Act and most of the other major proposals for health care reform rely heavily on the forces of competition to increase the availability and improve the quality of health care services, foster efficiency in the delivery of those services, and control their spiralling costs. For too long, the salutary effects of competition in health care marketplaces have been inhibited. Third party payment mechanisms that do not stimulate cost-effective consumer and provider decisions, limitations on the ability of consumers to choose health care plans on the basis of quality and price, and consumer unawareness of the merits and costs of the choices they do have are examples of inhibitions on competition that need to be addressed.

The Health Security Act promotes competition in many ways. The health care delivery system it will create will stimulate increased competition between

and among various types of health plans and between and among institutional and individual health care providers. Plans will compete to be selected by consumers by seeking ways to lower premiums and increase the quality of care through networks of qualified providers. Providers will compete to develop or participate in plans by demonstrating that they can provide high quality care at affordable prices, and by seeking innovative ways to offer that care. Consumers will have information that will make them better able to evaluate and select their health care coverage on the basis of cost and quality, and thus play their important role in stimulating effective competition among plans and providers. In short, the Health Security Act will promote competition to its rightful status as a major determinant in health care reform.

As we reform our health care system to rely heavily on increased competition, it is vital that we remember that promoting and protecting that competition requires effective prohibitions against private conduct that would undercut it. Fortunately, we do not have to invent such prohibitions: They have existed for a century in the form of our antitrust laws. Given the proposals for sweeping immunities from the antitrust laws or serious constraints on their effectiveness in some of the bills before the Congress, however, I fear that this

simple connection between increasing competition and preserving the laws that protect it may be overlooked as health care reform is pursued. That is a mistake we must not make.

Specific Antitrust Provisions in the Health Security Act

The Health Security Act contains two specific antitrust-related provisions. First, section 5501 of the Act repeals the broad antitrust immunity in the McCarran-Ferguson Act for the business of insurance to the extent that such business relates to the provision of health benefits. The current, broad immunity could allow health insurers to act anticompetitively and thereby interfere with the Health Security Act's goal of relying on competition between insurers to control health care costs.

The Health Security Act also provides that, in connection with the establishment by a regional alliance of a fee schedule for use in regional alliance fee-for-service health plans, health care providers may collectively negotiate the fee schedule with the regional alliance (section 1322(c)). This section recognizes that the establishment of such fee schedules by the alliances is basically a governmental function under the Act, and provides that the actions of

the alliances in this regard and their negotiations with providers collectively shall be accorded the antitrust treatment due to government actions and efforts by private parties to influence those actions (section 1322(c)(5)). Such actions and efforts generally are not subject to the antitrust laws, but under section 1322, as is the case generally, there are important limits on what actions providers may take to influence an alliance's fee-for-service schedule decisions. The principal limitation is that providers may not threaten or engage in any boycott to force an alliance to adopt their suggestions or recommendations (section 1322(c)(6)). As used in section 1322, the term "boycott" is intended to include any threat or action through which providers collectively would decline initially to participate, or departicipate, in fee-for-service health care delivery unless fees were set at certain levels.

* * *

Before concluding, I would like to underscore the one point I think is vital to keep in mind as antitrust issues are considered during health care reform. Among the primary goals of such reform is to bring the forces of competition effectively to bear in health care markets as never before. To accomplish this goal the efficacy of the antitrust laws must be preserved, and we seek the Subcommittee's support in this effort. The Department of Justice must

also continue to work with the FTC and the health care community to reduce unwarranted antitrust uncertainty in the health care area, which we have pledged to do.

Thank you again for the opportunity to submit to the Subcommittee the views of the Department of Justice on these important issues.

WRITTEN COMMENTS FOR THE RECORD

JUDICIARY COMMITTEE
SUBCOMMITTEE ON ECONOMIC AND COMMERCIAL LAW
HEARING HELD JUNE 15, 1994 ON
HEALTH CARE REFORM, ANTITRUST ISSUES

June 29, 1994

Submitted By:
Home Health Services and Staffing Association
119 South Saint Asaph Street, #115D
Alexandria, Virginia 22314

James C. Pyles
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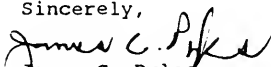
Dear Sirs,

Attached please find a statement of principles supported by the Market Access and Consumer Choice Coalition, of which the Home Health Services and Staffing Association (HHSSA) is a member, with respect to amendment of the antitrust laws under health care reform.

HHSSA opposes any amendment weakening the antitrust laws for the reason that it would erode patient choice and deprive qualified providers of access to the health care market. It is HHSSA's view that competition among health care providers should be preserved in order to promote cost effectiveness, quality, and innovation in the health delivery system.

We request that the Judiciary Committee incorporate the principles set forth in the attached paper in any health reform legislation it may consider. We would be pleased to answer any questions or provide any additional information the Committee might request.

Sincerely,


James C. Pyles

Enclosure

MARKET ACCESS AND CONSUMER CHOICE COALITION

May 9, 1994

The Market Access and Consumer Choice Coalition (MACCC) is a coalition of consumer and provider groups and associations that believe that quality, cost effectiveness, and innovation in the health care delivery system can best be ensured by preserving competition among providers as well as among health plans. MACCC members further believe that competition can be preserved only by affording consumers a meaningful choice of qualified providers where possible and ensuring that qualified providers have access to the health care market so they can demonstrate their merit to consumers.

Accordingly, MACCC urges Congress to incorporate the following principles into any health reform legislation:

I. PROTECTION OF COMPETITION UNDER THE ANTITRUST LAWS SHOULD BE PRESERVED

A. Anti-Competitive Activity Should Not Be Authorized

Any health reform legislation should state expressly that no provision in the Act is intended to authorize an activity or arrangement that would be prohibited under the antitrust laws. All proposals for exceptions, exemptions, and waivers should be rejected.

B. Procedures Should Be Established to Provide Greater Certainty and Clarity Under the Antitrust Laws

Greater certainty and clarity in the interpretation and application of the antitrust laws should be promoted by

- (1) Providing for an expedited business review procedure under which the Federal Trade Commission and the Department of Justice would respond promptly to requests for advance rulings concerning whether certain activities and arrangements would violate the antitrust laws; and
- (2) Providing for a process under which the Federal Trade Commission and the Department of Justice could issue antitrust enforcement guidelines based upon either their own initiative or when petitioned by private parties.

Rationale

The antitrust laws are designed to be sufficiently flexible to protect competition in furnishing all types of products and services under an infinite range of market conditions. These laws are the product of a century of experience and are the embodiment in the economic sector of a fundamental principle of our system of government -- equal opportunity under the law.

The promotion or preservation of competition in the health care delivery system is a basic concept in most of the health reform proposals. Only by preserving competition can Congress hope to enhance quality while controlling costs and encouraging innovation.

The antitrust laws should not be weakened by creating exceptions for certain professionals, providers, or activities. There is no reliable evidence that weakening the antitrust laws will reduce the cost of health care. Further, any exception for one type of professional, provider, or activity would surely be enlarged to include others. For example, if physicians were permitted to engage in price fixing, then other professionals and providers would claim the same privilege. Then health plans might assert the same right. The exceptions might well then have to be expanded beyond the health delivery area.

Any discussion of amending and weakening the antitrust laws is premature since it is unclear what type of health reform plan will be approved by Congress. For example, it would make little sense to amend the antitrust laws if health care reform amounted merely to incremental reform of the health insurance laws. Before taking such a drastic step, Congress should try less drastic measures such as providing for prompt rulings and issuance of clarifying enforcement guidelines.

II. PATIENT CHOICE AND MARKET ACCESS WITHIN HEALTH PLANS SHOULD BE PRESERVED

A. Health Plans Should Be Prohibited From Restricting Market Access and Reducing Patient Choice

Health plans, including integrated delivery systems, possessing market power, defined as 20% or more of the product or service market within a contiguous geographic service area, must provide an opportunity for participation by a sufficient number of unrelated providers to provide patients a meaningful choice based upon objective competitive criteria which are consistent with the purposes of the statute.

- (1) The burden of proof will be on the health plan to demonstrate that it either does not have market

power or that it has made participation available based on objective competitive criteria.

- (2) Any health plan which elects to make participation determinations based on objective competitive criteria must make the criteria known sufficiently in advance to afford all interested providers a fair opportunity to qualify for available openings.
- (3) Health plans possessing market power must provide an opportunity at least every two years for any interested provider, including those participating in the health plan, to demonstrate that they can fulfill the selection criteria better than other providers.
- (4) Health plans with market power must provide patients with a choice of unrelated providers, where available, and must honor the patient's selection of a provider.

Rationale

Health reform legislation should balance the desire to allow integrated delivery systems and managed care plans the opportunity to prove their validity in the marketplace against the right of patients to be able to obtain the health care of their choice.

There can be no meaningful choice for patients if providers are deprived of market access. Market access and patient choice become increasingly restricted as health plans attain significant market power. Accordingly, this proposal allows integrated delivery systems and managed care systems to operate with few restrictions so long as they do not exceed the market power threshold. Once they do, they assume a responsibility to the public to ensure that patients will continue to be able to select their providers based on the public policy objectives contained in the statute.

The burden properly rests on the health plans to demonstrate that they are below the market power threshold or have applied the objective criteria because they generally will possess the market data and will have control over whether they are above the threshold. Congress must avoid the situation where an integrated delivery system is permitted to gain market power, foreclose competitors from the market, and eliminate consumer choice. In such a case, patients will be forced to obtain health care from a provider based on corporate affiliation rather than on sound public policy objectives such as quality, cost, and patient satisfaction.

B. Network Health Plans Should Be Required to Adopt Provider Contracting Procedures That Preserve Patient Choice and Market Access

- (1) Contracts between network health plans (as defined in § 1402(f) of the Health Security Act) and providers should be based on full and open competition. Determinations by network health plans to enter into contracts with providers should be made under an open competitive process which utilizes objective selection criteria for each type of good or service furnished including quality, price, and patient satisfaction.
- (2) Network health plans should be precluded from using selection criteria which directly or indirectly discriminate against any health provider on the basis of type, class, or category of provider, or based on whether the provider is affiliated with a hospital or related entity.

Rationale

These provisions are intended to ensure patient freedom of choice and provider market access with respect to network health plans that provide benefits through contracts with providers.

The intent of these provisions is to afford qualified providers maximum opportunity to compete for contracts with network health plans through the use of the following procedures:

- (i) advance publication of objective selection criteria;
- (ii) advance public notice of when applications for participation are to be accepted;
- (iii) limiting the evaluation of applications to the published criteria;
- (iv) verification that providers have the capacity to accommodate the patients that the plan will be directing to them and that the quality of service provided will not be compromised by the price negotiated or by increased utilization;
- (v) periodic evaluations of participating providers and an "open season" at least every two years in which non-participating providers will have an opportunity to demonstrate that they can fulfill the selection criteria better than participating providers; and

- (vi) meaningful due process protections prior to termination or non-renewal of a provider contract.

III. ALL HEALTH PLANS SHOULD BE REQUIRED TO PRESERVE ACCESS TO OUT-OF-NETWORK HEALTH CARE PROFESSIONALS AND PROVIDERS

A. All Health Plans Must Offer A "Point-of-Service" Option

All health plans should be required to offer a "point-of-service" option to preserve patient choice and access with respect to out-of-network health care professionals and to enable such professionals to refer enrollees to out of network providers as deemed necessary, subject to reasonable patient premium and cost sharing requirements.

Rationale

Requiring health plans to provide a point of service option which is not subject to unreasonable coinsurance requirements should ensure that the patient's fundamental right to purchase the health care of his or her choice is preserved and that competing providers will be available when another opportunity becomes available to participate in a health plan.

IV. Enforcement

The entity charged with certifying the compliance of health plans with the requirements of the health reform act should ensure that health plans are in compliance with the foregoing requirements listed in I., II., and III. as a condition of being permitted to offer benefits under the Act.

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STATEMENT TO THE SUBCOMMITTEE ON ECONOMIC & COMMERCIAL LAW
REGARDING SOME ANTI-TRUST ISSUES IN HEALTH CARE

JUNE 15, 1994

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Good Morning, Mr. Chairman. As a cancer patient, my greatest concern is that Congress will lose sight that health care reform is about helping sick people. We need health care reform which is pro-consumer, squarely on the side of the patient. Every part of the health care reform legislation should be evaluated in terms of its impact on consumers, including anti-trust proposals.

Exemptions from Anti-Trust

Some health care providers are advocating exemptions from anti-trust law. Many arguments are put forth to justify such exemptions. Doctors say they need to counter balance the power of large HMO's. Hospitals say they need to collaborate and eliminate duplication of facilities and equipment such as high priced MRI machines.

These proposals are highly suspect. Anti-trust laws are designed to foster competition, reducing prices to the underlying costs of goods and services.

Exemptions for Physicians

Physicians claim that they are seeking anti-trust exemptions so (1) they can work together to reduce costs through sharing arrangements, and (2) compete more effectively against large HMO's or bargain collectively with HMO's.

It is true that sharing arrangements may reduce cost. However, anti-trust exemptions are not needed to create sharing arrangements. Physicians are free to create corporations and other entities which will own or finance equipment or facilities which are leased to different physicians or practice groups. For example, common areas in a medical office building are shared by all tenants. Such arrangements do not violate anti-trust laws, and no exemptions are needed.

Similarly, to bargain collectively with HMO's or other medical networks does not require anti-trust exemptions. In fact, physicians who are real experts in their field will be better off not participating in collective arrangements. Like super star athletes, the best physicians can obtain legal assistance and negotiate their own special contracts with HMO's and networks.

The real motivation of physicians is price fixing and to limit competition.

Exemptions for Hospitals, HMO's, Etc.

Some hospitals and HMO's are advocating anti-trust exemptions so they can share expensive pieces of medical equipment and build facilities which will be jointly owned or operated. In their view, costs will be reduced by restricting supply and reducing excess capacity. However, this view is questionable.

It is true that one hospital which has an MRI machine or other advanced equipment may have an advantage over a competitor that does not. However, by allowing anti-trust exemptions for the purpose of sharing equipment and facilities, technological competition is reduced. Anti-trust exemptions are being sought because hospitals and HMO's do not want to compete for patients and doctors.

We do not have too many MRI machines. There is no such thing as excess supply of high technology medicine. The easy availability of high tech medicine benefits consumers, producing better diagnoses, outcomes, and lower costs. Hospitals which have state-of-the-art equipment can also attract the best and brightest doctors and researchers.

The problem is the price of using advanced technology and medical facilities. The business of medicine has created conflicts of interest and normal price mechanisms for matching supply and demand have been thwarted.

For example, physicians should not be allowed to have a financial interest in facilities where they refer patients for tests or treatment. Many doctors require X-rays for diagnosis or radiation treatments for patients. It is a conflict of interest for doctors to have a financial interest in radiology centers which do such work because such doctors have a financial incentive to over prescribe radiology services. This is particularly under third party payment schemes.

Laws are needed to restore the price mechanisms to full strength and protect consumers. Laws should provide for all users of facilities or services to be informed of the price prior to treatment. We have such disclosure laws in banking and many other industries, and they contribute to market efficiency.

Anti-trust exemptions which restrict the supply of facilities and technology by allowing health care providers to collaborate are anti-consumer. Total underlying costs may be reduced, but there is no guarantee that prices will drop. In fact, profit margins of providers will rise.

The Lessons of History

I urge the Subcommittee to reject all proposed anti-trust exemptions as part of health care reform. They are anti-consumer and anti-patient. The free market will work, but we need to set the stage so the price mechanism truly works. If the price mechanism is fully functional, the free market will allocate resources most efficiently.

I remind the Subcommittee of the McCarren-Ferguson Act, which was passed with good intentions. It was also supported with what appeared to be sound arguments at the time. However, it has proven to be extremely anti-consumer and anti-patient, leading to higher prices for insurance coverage. It has not served the public. Do not make the same mistake with proposed anti-trust exemptions for health care providers. Learn the lesson of history.

Unitary Pricing on Drugs

The legislation proposed by the President, now in various Congressional committees, has "unitary pricing" requirement which is anti-competitive and anti-consumer. I urge this Subcommittee on Economic and Commercial Law to hold hearings as to why such a provision of the proposed legislation is in the public interest or to strike the "unitary pricing" provisions from the legislation.

Under the proposed legislation, a drug manufacturer must offer the same price to all customers (HMO's, pharmacy chains, etc.) who purchase on the same terms. This provision disregards the fact that different buyers may constitute different classes of trade.

For example, large HMO's and drug benefit management companies such as Medco Containment have consumers who are in essence "subscribers" to services and drugs. Retail pharmacies which rely on "walk-in" customers do not have a subscriber relationship with their customers.

Drug manufacturers are willing to compete aggressively and give deeper discounts to HMO's and other resellers which have subscribers. The reason is that the cost of acquiring a patient or end-user customer is less and the probability of repeat purchase is greater when dealing with a reseller which has a subscriber customer base.

According to retail pharmacists, "unitary pricing" is needed to "level the playing field" by allowing retail pharmacists to buy on the same terms as subscriber type buyers. However, consumers will pay more for drugs if the "unitary pricing" provisions of the proposed legislations are enacted.

"Unitary pricing" is really an anti-discounting provision which says that no buyer should get a better discount than retail pharmacists. It ignores the fact that while terms of sales can be the same, "conditions of sale" are different, and that some resellers have a very different relationship with end-user patients than other resellers.

"Unitary pricing" will reduce competition among resellers of drugs. Resellers will no longer need to negotiate aggressively to get the best price. Competition for patients will be diminished. For example, retail pharmacists will not need to provide high levels of services or to be as innovative if price competition is reduced.

The National Association of Retail Druggists (NARD) and the National Association of Chain Drug Stores (NACDS) have endorsed President Clinton's proposed legislation because of "unitary pricing." The reason is that these types of merchants are under new competitive pressures from Wal-Mart, HMO's, mail order pharmacies such as AARP, Medco Containment, and other new resellers. These organizations did not even exist ten or fifteen years ago.

Retail druggists are seeking relief from these new competitors and changes in the retail pharmacy market. However, the public will pay more for drugs if retail pharmacists are protected from competition and anti-discounting legislation is enacted. The public should get the benefits of new competition and new ways of doing business. The public should not be required to pay to protect inefficient channels of distribution from competition.

In seeking relief from competition, retail pharmacists are turning to government rather than competing in the marketplace and serving patients better. This Subcommittee must not allow competition for political influence to be a substitute for competition in the marketplace.

At one time, every drug store had a soda fountain where sandwiches, ice cream, and sodas were sold. These soda fountains were "America's fast food outlets." McDonald's and other fast food chains made drug store soda fountains obsolete. Many drug stores removed their soda fountains and changed their merchandising.

Drug store chains and retail pharmacists will have to adapt again and become more innovative if they are to retain their customers and maintain their revenues. This need to innovate will serve consumers and patients.

I urge this Subcommittee to remove the "unitary pricing" provisions from the proposed legislation. Let the free marketplace serve patients and customers.

In any case, health care reform legislation does not need "unitary pricing." Robinson-Patman is the law of the land. We have the Federal Trade Commission which is required to enforce Robinson-Patman. Let the Federal Trade Commission and the courts sort out this issue if the Subcommittee is uncertain about what to do regarding "unitary pricing." We don't need more legislation.

DECEMBER 27, 1993

FORTUNE

HEALTH CARE

THE PLOTS TO KEEP DRUG PRICES HIGH

At long last, drugmakers are discounting—and often hating it. A bizarre cast of Bill Clinton, Jesse Jackson, and your local pharmacist would call a halt. ■ by Shawn Tully

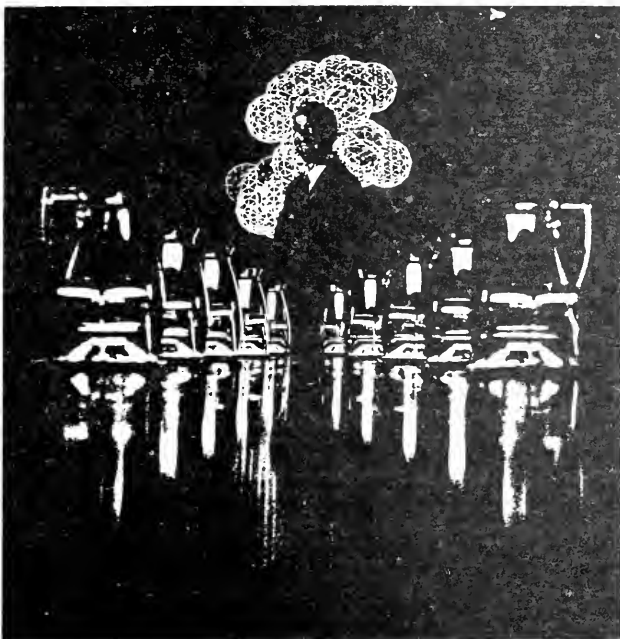
PICTURE a mythical market from a business version of *The Arabian Nights*. Buyers rush about the souk, striking luscious bargains for dates and spices. Shrewd merchants offer special terms to customers who place caravan-size orders. I'll give you a much lower price if you give your business to me rather than to the neighboring date stand.

Then two portly customers are borne in on groaning sedan chairs. Abdul and Saud shun the meise. I am the state, Abdul roars. The lowest price you merchants grant to any customer, you must also offer me—though I won't promise you any extra business. He grins at the mountainous Saud, a private buyer who also disdains bargaining. And the same goes for my friend Saud. He deserves your best price, no matter how much—or how little—he feels like buying.

The merchants quickly find that when forced to grant big discounts to Abdul and Saud without getting extra volume in return, they lose the profits gained in their discount deals with other buyers. In fact, the only way they can restore profits is by taking back those discounts. Not much point in haggling now—the sellers can no longer afford to cut prices much. The din of bargaining subsides as the spectacle of a teeming marketplace fades like a mirage in the desert.

That tale is a parable for what could happen to today's drug market. Abdul and

REPORTER ASSOCIATE JAMES L. DAVIS



"Our concept of best-price for Medicaid—now incorporated in federal law—was supported by our longstanding strategy of avoiding deep discounts."

—P. ROY VAGELOS
CEO, MERCK

Saud—the federal government and America's retail pharmacies—threaten to halt the wave of competition in drug pricing that is just beginning to roll. The wave was unleashed by nimble, bargain-hungry customers like HMOs and mail-order houses that press physicians to prescribe low-priced drugs.

Shackling this market would be tragic because competition is working. Drug prices rose at a 3.3% annual rate in the first nine months of 1993, one-third the rate of 1990. Although companies were likely restraining prices to ward off the threat of price controls, the main factor was increased competition in the market.

A major force has been the explosion in the supply of similar or identical drugs. That growth isn't limited to the so-called generics, cheap copies of brand-name drugs that appear after the patents expire. Expensive patented products now face strong competition as well. It comes from what are known as me-too drugs, newly patented rivals that are chemically different but have the same medical effect. Crowding the market, for example, are eight patented, virtually interchangeable "ace inhibitors" for hypertension and four copycat ulcer drugs.

SURROUNDED by choices, powerful buyers such as HMOs, hospitals, and mail-order firms are driving down prices. The key to securing discounts isn't mainly size but the ability to shift market share. By granting a big HMO a 25% discount in exchange for a 100% increase in volume, a manufacturer can generate a pile of extra profits. That's the bait that draws producers into price competition.

Wait a minute—where has all this competition been the past several years? Why have we heard so much about drug prices rising steeply until quite recently? The answer is that buyers have lacked the leverage to change market share. Now they're seizing it. HMOs and mail-order houses, which send patients drugs for chronic illnesses, take bids from manufacturers on all the similar high-quality



"The drugstores want the same discounts as the buyers who really move market share."

—TRAVERS WILLS
CEO, DIVERSIFIED PHARMACEUTICAL SERVICES

drugs in each category and put the lowest-priced products on lists of preferred drugs called formularies. Then they prod doctors to prescribe the drugs on the formularies. The preferred drugs quickly gain market share, while overpriced products languish.

The effects of this bargaining are in the newspapers every day, as drugmakers slim down to meet the rigors of real competition. Merck, Warner-Lambert, and other drug giants have announced 30,000 layoffs in the past year.

But the Clinton health care reform plan—think of it as the Abdul plan—and lawsuits filed by the pharmacists—call them Saud suits—would penalize manufacturers that grant discounts in exchange for extra business from sharp-penciled customers. Why? The manufacturers would be forced to offer the same low prices to these passive buyers who have no influence on market share. Since drugmakers couldn't afford to offer deep discounts to the whole market, today's feverish bargaining would cool way down. The pharmaceutical manufacturers would take on the bloated, jowly look of a public utility.

We've been down this road before. The

state Medicaid agencies, which buy 12% of the drugs in America, began to flex their muscles in the late 1980s, pushing down prices by establishing formularies and using red tape to discourage doctors from prescribing costly drugs. Pharmaceutical companies feared their biggest customer would shut out their expensive new products.

So in 1990 the industry struck a bargain. Drugmakers agreed to give Medicaid a flat rebate off the wholesale price of all their drugs. The rebate is currently 15.7%. In exchange, Medicaid banned the formularies drugmakers dreaded and agreed to pay for any new drug a doctor cared to prescribe for at least six months.

For HMOs and mail-order drug sellers, the legislation contained a dagger in the guise of the so-called best-price provision. Say a manufacturer is selling a drug to HMOs and other buyers at discounts as deep as 30%. It

must then offer Medicaid not the standard 15.7% reduction but the "best price" it is granting any private customer—in this case, 30% off. This provision split the industry. Merck and Pfizer, two companies that resist deep discounting, strongly supported the measure, with enthusiastic backing from the retail druggists. In the opposition were avid price cutters like Upjohn and Glaxo, which rightly feared that the best-price policy would hamper competition.

Best-price is working brilliantly for its proponents. By forcing drugmakers to extend discounts to Medicaid for no additional business, it makes price cutting far more expensive. The manufacturers' response is simple: On many drugs, no buyer gets a discount deeper than Medicaid's 15.7%. The losers are the most powerful buyers like HMOs and hospitals, which frequently received discounts of 40%, 50%, or more. "In the past we'd offer a manufacturer 90% of our business, maybe \$10 million in additional business, and get really low prices," says Dale Kramer, director of drug purchasing for Kaiser Permanente, America's largest HMO. "Now no one wants to go below the Medicaid floor."

Kramer reckons that best-price has raised Kaiser's bill for patented prescription drugs \$50 million a year, or 10%. The price Kaiser pays for Coumadin, an anticoagulant for heart patients from Du Pont-Merck, jumped from \$4 per 100 tablets to \$40. As price cutters predicted, they are suffering. The Glaxos and Upjohns of the world often can't afford to lower prices enough to win market share from the Mercks and Pfizers. "Best-price should be abolished," says Mitch Daniels, head of North American pharmaceutical operations at Eli Lilly, another aggressive discounter. "You'd only like it if you were a tax collector."

Trying to push drug prices down, Congress earlier this year partly undid the 1990 deal between the Medicaid agencies and the drugmakers. Once again the Medicaid buyers may use formularies and behave like competitive private buyers. Instead of reimbursing whatever doctors prescribe, the Medicaid agencies may put their business out to bid a la Kaiser, trading extra sales for low prices. States can drive rebates far below the 15.7% minimum. California's Medicaid agency, Medi-Cal, has established what amounts to a restrictive formulary. Medi-Cal has decided to pay for just two of the four ulcer drugs on the market, SmithKline Beecham's Tagamet and Merck's Pepcid. In exchange for the deal, Medi-Cal secured discounts from both manufacturers.

So far, California is an exception. Drugmakers are mounting a crusade to stop states from setting up restrictive formularies and have recruited an unlikely ally: minority groups led by Jesse Jackson's Rainbow Coalition. The strange of bedfellows, black leaders and drug executives testify to the same state legislative committees to denounce formularies. The manufacturers and putative minority advocates claim that formularies foster second-class medicine by denying the best drugs—by which they mean the most expensive—to the poor. Never mind that less costly drugs are often medically identical to the pricier competitors. The argument is proving



"In the past we'd offer a manufacturer 90% of our business and get really low prices. Now no one wants to go below the Medicaid floor."

—DALE KRAMER

KAISER PERMANENTE

highly effective, with New Jersey, Washington, and other states announcing they have no plans to restrict drugs. The drugmakers haven't won yet. If California demonstrates that formularies produce big savings for consumers, budget-strapped states might follow.

ANOTHER CHALLENGE to competition comes from a different adversary: America's 60,000 retail pharmacies. Drugmakers grant them few if any discounts, for a simple reason: Pharmacies have little power to shift market share. Their job is to sell whatever doctors prescribe. Big retail chains like Rite-Aid get small discounts for buying huge volumes. But since they can't lure manufacturers with extra orders, they pay far more than mail-order houses.

To stop their decline, the druggists are suing to get the same prices as mail-order firms and other more powerful competitors. Among other suits, Rite-Aid, Revco, and eight other chains and ten independent drugstores are charging the largest mail-order seller, Medco (now owned by Merck), and five manufacturers with violating the Robinson-Patman Act. This 1936 federal law bans "price discrimination" among different customers. Under the courts' interpretation of Robinson-Patman, a company must offer the same price to all buyers in the same "class of trade." To justify the

same class of trade as HMOs and mail-order firms.

A Pennsylvania court will likely decide the case next year. A win for the pharmacists would produce a seismic shock. Tightly enforced, Robinson-Patman limits competition. For companies in the same class of trade, the law doesn't accept the power to move market share as a justification for different prices, even though that is the real motive behind manufacturers' discounts. The law permits prices to vary primarily to reflect cost savings, mainly from processing and transporting large volumes. The burden of justifying price differences falls on the manufacturer. If the druggists win, the result is inescapable: With minuscule variations, drugstores, mail-order firms, and pharmacy management companies would pay the same prices for drugs.

Victory for the druggists would have an effect similar to that of Medicaid's best-price policy. Discounting would become more expensive, and sellers would raise prices toward what the druggists pay: full wholesale. This time the victims wouldn't be just powerful buyers like large HMOs. The single price would wipe out the modest discounts for mail-order and pharmacy benefit management companies such as Diversified Pharmaceutical Services of Bloomington, Minnesota. Says Max Fern, a consultant to drug manufacturers: "It

wide range in prices, the drugmakers claim that HMOs, mail-order companies, drugstores, and other buyers are distinct types of customers that offer different services. HMOs market formulary drugs to their own doctors, for example, while boosting drugstore sales is a different proposition, requiring an army of salespeople to woo doctors.


Bunk, say the pharmacists. They claim a conspiracy. Manufacturers charge, subsidize huge discounts to HMOs and mail-order companies with inflated prices to drugstores. The pharmacies demand a ruling that would put them in

HEALTH CARE

would lead to higher prices than you'd see under free competition." (Little wonder that for years the Justice Department has not enforced Robinson-Patman, considering it anticompetitive and anticonsumer.)

The Clinton health care plan would give Abdul and Saud considerable new power. It would authorize vast new purchasing of drugs under Medicare and force manufacturers to grant Medicare a 17% rebate, with price rises thereafter limited to inflation. It would also include a provision similar to the Medicaid best-price policy. The Medicare measure would effectively set a floor under discounts at 17%. And just in case the pharmacists lose their suit, the plan would basically enforce Robinson-Patman for them by making it far more difficult for manufacturers to offer deep discounts to HMOs and mail-order houses in exchange for more business. Likely result: All private buyers would pay nearly the same price for drugs, and that price would be close to full wholesale, since discounting would be penalized.

ANOTHER EFFECT of the Clinton plan: It would douse drugmakers' incentives to develop new drugs. Today the only products still immune to price competition are totally original drugs like Cognex, the new Alzheimer's drug from Warner-Lambert. So potential profits from breakthrough drugs should continue to attract huge investments in research. But the Clinton plan threatens to wreck those incentives with price controls. Under the plan, if the Secretary of Health and Human Services deems any new drug too expensive, he or she can demand a discount beyond the standard 17%. If the manufacturer refuses, the Secretary can ban it from coverage under Medicare or require that the U.S. price match the lowest price in any of 21 other countries, including France, Canada, Portugal, Australia, and New Zealand, many of which have lower living costs than the U.S. and strict government controls on drug prices.

What would the Clinton plan mean for the private market? An abrupt end to intensifying competition that is finally starting to hold drug prices down. For the growing numbers of Americans who get drugs through mail-order sellers, pharmacy management firms, HMOs, and other providers of managed care, prices would jump back up toward regular retail—and the days of negotiating a terrific deal in the open market would come to an end. 

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